

052055

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 7 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HERBERT McCLELLAN ASH			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1986			2b. HOUR 11:15 a. m.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 21 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8b. CITIZEN OF WHAT COUNTRY? USA		8c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED STATE ROAD DEPT.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FLINTSTONE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE STAR ROUTE BOX# 3 21530	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS R. ASH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH SMITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-05-9845		17. INFORMANT ADDRESS MILDRED ASH STAR ROUTE FLINTSTONE MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent Lymphoma. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE MD			22c. DATE SIGNED 2/6/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Qamar Zaman			22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB 9 1986		23c. NAME OF CEMETERY OR CREMATORY GLENDAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FLINTSTONE ALLEGANY MD.			
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND			ADDRESS		25. POWERED BY THE REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the body of the deceased and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

042036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 7 3

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) SADIE REBECCA ATHEY			2a DATE OF DEATH MONTH DAY YEAR February 1, 1986		2b HOUR 10:25 P. M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jun. 11, 1910		
6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b KIND OF BUSINESS OR INDUSTRY Own Home		13a STREET ADDRESS / ZIP CODE Rt. # 1, Box 189 21555				
13b STATE MD		13c CITY OR TOWN Oltown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST James Robert Mullenax		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Teter				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-16-2439		17 INFORMANT ADDRESS Mary Danner Sring Gap, MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Right CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Atrial fibrillation Pneumonia						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from 2/1/86 to 2/1/86 , that (we) last saw the deceased alive on 2/1/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Shawn A. Nathan		DEGREE		22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Nathan		22e ADDRESS Memorial Hospital Medical Building, Cumberland, MD 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Feb 4, 1986		23c NAME OF CEMETERY OR CREMATORY Mt Tabor Cemetery Spring Gap Allegany MD		
23d LOCATION CITY OR TOWN COUNTY STATE Allegany MD		24 FUNERAL DIRECTOR NAME ADDRESS William G. Kight Cumberland, MD				
25a DATE RECD. BY REGISTRAR FEB 07 1986		25b REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

William G. Knight Cumberland, MD

Pop 4, 1986 Mt Tabor Cemetery Spring Gap Allegany MD

no

James Robert

Mullenax

Fannie

Teter

Mary Danner

Spring Gap, MD

MD

Allegany

Olton

X

Rt. 4, Box 189 21553

Housewife

Own Home

W. Va.

USA

White

Jan. 11, 1910

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GEORGE UPCHURCH FUNERAL HOME STATE OF MARYLAND
 202 GREENE STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

8 6 0 3 2 7 4

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
JEANNETTE M BARRETT		FEBRUARY 16, 1986		3:25 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	February 11, 1901	85 YRS	ALLEGANY COUNTY MD.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		ALLEGANY COUNTY		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	SACRED HEART HOSPITAL	Clerk-County Commissioner Office			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	215 Saratoga Street / 21502	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
William Howard Barrett	Sophia Marie Schauwecker		No		
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
215-36-9714		Ruth McKenzie (Sister) Hanahan, South Carolina			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>High Probability of Pulmonary Embolism</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Subacute CHF & prolonged bed rest</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Hypertension - CHD -</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Renal failure</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>86</u> , to <u>2/16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>V. Raul Felipa M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>2/17/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
V. Raul Felipa, M.D.		925 BISHOP WALSH ROAD CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	2-19-86	hillcrest Burial Park	Cumberland-Allegany-Maryland		
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502		FEB 20 1986		<u>[Signature]</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of grade.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

150-37-212

057073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a medical certification completed.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RANDALL ELWOOD BEACHY			2a. DATE OF DEATH MONTH DAY YEAR 2/18/86			2b. HOUR 1740 P_M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1913		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13204 Second St. / 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Oliver G. Beachy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arletta Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-07-2549		17. INFORMANT ADDRESS Mrs. Theresa Tysinger Ridgeley, W.VA.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Prostate Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 165		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN USUAL PART I OR PART 2) N/A						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY LAT HOME, STREET, FACTORY, OFFICE, FARM, ETC. N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A						
22a. I certify that (1) (this hospital) attended the deceased from 3/15 19 86 , to 2/18 19 86 , that (1) (we) last saw the deceased alive on 3/15 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bruce D. Behringer, MD				DEGREE				22c. DATE SIGNED 2/20/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce D. Behringer, MD				22e. ADDRESS BMG, 912 SETON DR. CUMBERLAND, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/86		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Avilton, Garrett, MD				
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. LaVale, MD				25a. DATE REC'D. BY REGISTRAR FEB 24 1986		25b. REGISTRAR'S SIGNATURE <i>John J. Hafer, Jr.</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JAMES ALLEN BLACK			2a. DATE OF DEATH MONTH DAY YEAR February 19, 1986		2b. HOUR 5:15 M
3. SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 05-17-1913		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OH	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired president Newspaper		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b COUNTY Allegany	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Blanchard Black		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mertie Ellen Loehr			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17 INFORMANT ADDRESS Mrs. Alice Black, Cumberland, MD - wife		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermoid Carcinoma, Lung.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Chronic Obstructive Lung Disease</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>12-17</u> 19 <u>86</u> to <u>2-19</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2-19</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Dr. Barrera</u>		DEGREE MD		22c. DATE SIGNED 2-19-86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Barrera		22e ADDRESS Memorial Hospital Medical Building Cumberland, Md. 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 02-19-1986	23c NAME OF CEMETERY OR CREMATORY Rosedale Funeral Chapel		23d LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV	
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a DATE REC'D BY REGISTRAR FEB 24 1986		25b REGISTRAR'S SIGNATURE <u>John Davidson</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return random carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/00 BY SP-6 [illegible]

REASON FOR DECLASSIFICATION [illegible]



DECLASSIFICATION AUTHORITY [illegible]

DATE OF REVIEW [illegible]

10/1/00

10/1/00

10/1/00

055157

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 3 2 7 7
2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Feb. 14 1986 2b. HOUR 9:25 P.M.

FOR STATE REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

LAST

Helen

Louise

Bradshaw

2. SEX

Female

4. RACE

White

3. DATE OF BIRTH
MONTH DAY YEAR
8-03-236. AGE (IN YEARS LAST BIRTHDAY)
62 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

Feb. 14 1986

2d. HOUR 9:25 P.M.

12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD.

18. CITY OR TOWN OF DEATH

Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Sales Clerk

12b. KIND OF BUSINESS OR INDUSTRY

Business

12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

12a. STATE
West Va.12b. CITY
Mineral13c. CITY OR TOWN
Ridgeley13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS

P.O. Box 418 / 26753

14. FATHER'S NAME

Hugh

Ernest

Nester

15. MOTHER'S MAIDEN NAME

Ada

M.

Plum

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

--

17. INFORMANT

215-12-2352

17. INFORMANT

Robert D. Bradshaw

ADDRESS

P.O. box 418

Ridgeley, W. Va.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Metabolic Acidosis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) Diabetes

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

2/14/86

EXAMINER'S NAME (TYPE OR PRINT)

Francisco Reyes, M.D.

ADDRESS 900 Seton Drive-Cumberland, Md 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

2-17-86

23c. NAME OF CEMETERY OR CREMATORY

Rest Lawn Meml. Gdns.

23d. LOCATION (CITY OR TOWN)

LaVale-Allegany-Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

George-Upchurch Funeral Home, P.A.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

202 Greene Street-Cumberland, Maryland 21502

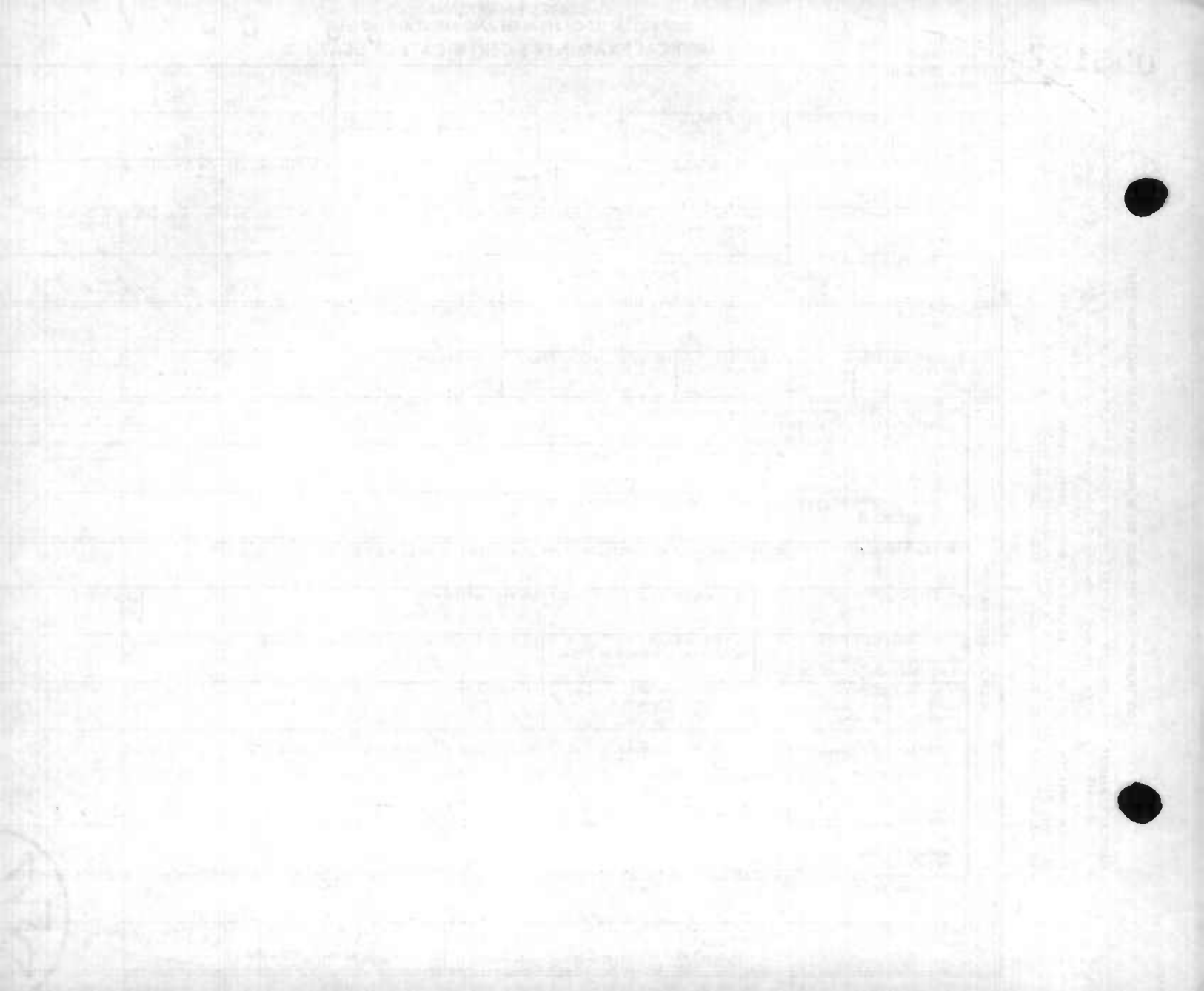
FEB 20 1986

j...

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

999997



070124

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL Eyerly BREWER			2a. DATE OF DEATH MONTH DAY YEAR February 24, 1986			2b. HOUR T:45 P. M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Service	
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Abner Brewer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie A. Eyerly			16. ADDRESS Bethesda, Md. 20816			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-14-7250		17. INFORMANT Carrie E. Barbato 4952 Sentinel Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>day 1</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/24/86</u> to <u>2/24/86</u> , that I (we) lost <u>view of the deceased</u> on <u>2/24/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (do not) see the body after death.)									
22b. SIGNATURE <u>Dr. Fiscus</u>			DEGREE			22c. DATE SIGNED <u>2/24/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Fiscus			22e. ADDRESS Memorial Hospital Med. Bldg., Cumberland, M D 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-26-86		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.		
24. FUNERAL DIRECTOR NAME Gerald N. Minnich			ADDRESS 305 N. Potomac St. Hagerstown, Maryland			25. DATE RECEIVED BY REGISTRAR FEB 28 1986			
26. REGISTRAR'S SIGNATURE <u>Gerald N. Minnich</u>			27. REGISTRAR'S SIGNATURE <u>Gerald N. Minnich</u>						

MEDICAL CERTIFICATION

BP
DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. This permit must be given to the funeral home prior to removal of the body from the State Dept. of Health and Mental Hygiene prior to removal of the body from the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

052118

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6

03279

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD CALVIN BROOME, SR.			2a. DATE OF DEATH MONTH DAY YEAR February 11, 1986		2b. HOUR 2 P.m.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 08-06-1922		
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		
12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland				
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 202 Wilmont Avenue/21502				
14. FATHER'S NAME FIRST MIDDLE LAST Albert H. Broome			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Susanne Oglesbee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II/Korean 233-34-5621		17. INFORMANT ADDRESS Mrs. Louise M. Broome, Cumberland, MD - wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Advanced oat cell Ca. Lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. That (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/12/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Qamar Zaman		22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 02-14-1986		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gard		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				
25a. DATE REC'D. BY REGISTRAR 10 14 86		25b. REGISTRAR'S SIGNATURE 				

MEDICAL CERTIFICATION

100000

20% C. O. H. 11238

CHATELAIN BOND

(SAR)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 0

055059

FOR
1- STATE
REGISTER

REG. NO.

1. DECEASED NAME (PRINT COMPLETELY) REUBEN William BROWN			2a. DATE OF DEATH MONTH DAY YEAR 2 14 86			2b. HOUR 6:15 PM	
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 22 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Ephrin E. Brown		15. MOTHER'S MAIDEN NAME Virginia S. Diddawick		16. STREET ADDRESS 14 Arch Street		21502	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. 218-16-3716		17. INFORMANT Margaret V. Brown		same as 13a-e.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro-Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Carcinoma of Prostate Gland.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> , 19 <u>85</u> , to <u>2/14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.							
22b. SIGNATURE <u>S. M. Shrestha</u>		DEGREE M.D.		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. M. SHRESTHA.		22e. ADDRESS THE MEMORIAL HOSPITAL CUMBERLAND, Md. 21502					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/17/86		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial LaVale		23d. LOCATION CITY OR TOWN COUNTY STATE Allegany MD	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR FEB 20 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Rest low

070002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 1

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MARY Virginia CALANDRELLA			2a. DATE OF DEATH MONTH DAY YEAR February 22, 1986			2b. HOUR 2:45A M				
3. SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 5 1909		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 77 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY Garrett		13c. CITY OR TOWN Kitzmiller		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Main St. 21538	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Weicht			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Arnold							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-74-5875		17 INFORMANT ADDRESS Dr. Ralph Calandrella Kitzmiller, Md					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE hour	
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Emphysematous Chronic Obstructive Lung Disease		10 years	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **N/A**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from 2/18 19 86 to 2/22 19 86 , that (I) (we) last saw the deceased alive on 2/22 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hawale				DEGREE MD		22c. DATE SIGNED 2/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Diener				22e. ADDRESS Cumberland Memorial Hospital & Medical Center 600 Memorial Ave., Cumberland MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-24-86		23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elk Garden Mineral W.Va	
24 FUNERAL DIRECTOR David A. Burdock Kitzmiller, Md. 21538				25a. DATE REC'D. BY REGISTRAR MAR 7 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SECRET

NOTION FILE

SECRET
MAY 11 1960

065193

1. FOR
STATE
REGISTRARSCARPELLI FUNERAL HOME
VIRGINIA AVE.,
CUMBERLAND, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 3 2 8 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE VIRGINIA CARDER			2a. DATE OF DEATH MONTH DAY YEAR 2/18/86		2b. HOUR 1910 P M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09-28-1908		
6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KS		7b. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE WV		13b. CITY OR TOWN Ridgeley		13c. STREET ADDRESS / ZIP CODE Route 2/26753 99999		
14. FATHER'S NAME FIRST MIDDLE LAST Frank E. Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Ann Heffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 236-64-8231		17. INFORMANT ADDRESS Mr. Ray B. Carder, Ridgeley, WV - husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF - intra-pulmonary bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Non-union of left femur fr.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> 19 <u>86</u> , to <u>2-18</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>2-18</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>John Mehan</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-19-86		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN MEHANNA		22c. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-22-1986		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		
23d. LOCATION CITY OR TOWN COUNTY STATE Points Hampshire WV		23e. DATE REC'D. BY REGISTRAR				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

0853 03

SCARLETT FURNACE
VIRGINIA AVE.
GREENLAND, VT 05743

CERTIFICATE VIRGINIA CARD

DATE

ALLEGY

SACRED HEART HOSPITAL



DR. J. J. J. J.

910-3-3000 MONI DRIVE, GREENLAND, VT 05743

070160

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary E. Carter			2a. DATE OF DEATH MONTH DAY YEAR 02 22 86		2b. HOUR 7:43 A.M.		
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6/16/1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEMOTHER		12b. KIND OF BUSINESS OR INDUSTRY COLLEGE	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK H. CROW		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE CHANEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-34-3081	
17. INFORMANT ST., FROSTBURG, MD 21532		17. INFORMANT MRS. LYDIA HIMMELWRIGHT, 345 ALLEGANY		18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pneumonitis. DUE TO, OR AS A CONSEQUENCE OF (b) Acute viral syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Chronic ASACEND.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-19-80 to 2-22-86 , that (I) (we) lost saw the deceased alive on 2-18-86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE V. A. Ranjithan				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-24-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.				22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 2/26/86		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD	
24. ELDERLY DIRECTOR 60 W. MAIN ST.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 28 1986	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

206-10110-1000

206-10110-1000



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGARET GERTRUDE CLARK			2a. DATE OF DEATH MONTH DAY YEAR February 19, 1986			2b. HOUR 1:50 AM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 06-06-1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY Post Office	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE none/21530	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Silver					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Anna Nolte				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-58-1545		17. INFORMANT ADDRESS Mrs. Margaret K. McFarland, Flintstone, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Renal Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/19 , 19 86 , to 2/19 , 19 86 , that (I) (we) last saw the deceased at 2/17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE at Baller				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 19 Feb 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-22-1986		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley Springs WV			
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR EB 24 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) NETTIE DOUGLAS CLARK			2a DATE OF DEATH MONTH FEB DAY 4TH YEAR 1986		2b HOUR 1017 HRS M	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH 04 DAY 02 YEAR 1913		
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY HOME	
10 CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF OTHER THAN HOSPITAL, GIVE STREET ADDRESS) CUMB MEMORIAL HOSPITAL			
12a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND			13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND	
14 FATHER'S NAME FIRST JOHN MIDDLE - LAST RICE			15 MOTHER'S MAIDEN NAME FIRST MAE MIDDLE - LAST WADSWORTH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 219 44 0129		17 INFORMANT ADDRESS 1037 FREDERICK ST. CUMBERLAND, MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular Instability</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ventricular Instability</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>1-31-86</u> to <u>2-4-86</u> , that (I) (we) lost saw the deceased alive on <u>1-31-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>2-4-86</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR A BARRERA				22e ADDRESS MEDICAL BUILDING CUMBERLAND MD MEMORIAL HOSPITAL		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 2-7-86		23c NAME OF CEMETERY OR CREMATORY ST. LUKE'S LUTH. CEM.		
24 FUNERAL DIRECTOR NAME GEORGE-UPCHURCH FUNERAL HOME, P.A. ADDRESS 202 GREENE STREET-CUMBERLAND, MARYLAND 21502		25a DATE REC'D. BY REGISTRAR FEB 10 1986		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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1073 HRS 1980 FEB 13 1980 KETTIE DOUGLAS CLARK

WHITE 13 23 ALLEGANY COUNTY UNITED STATES

CLARK HOSPITAL ALLEGANY COUNTY

CLARK HOSPITAL ALLEGANY COUNTY



RECEIVED FEB 13 1980

CLARK HOSPITAL ALLEGANY COUNTY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 6

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM EDWARD CLAUSON			2a. DATE OF DEATH MONTH DAY YEAR February 3, 1986		2b. HOUR DAY MIN. 7:45 P.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09/20/05		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY textile manuf.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Corriganville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE P O Box 117/21524			
14. FATHER'S NAME FIRST MIDDLE LAST John E Clauson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara M Knepp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-1044		17. INFORMANT ADDRESS William M. Clauson, Corriganville, MD 21524			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute left ventricular failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic cardiomyopathy</u> SPECIFIC TIME INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>4 hrs</u> <u>year</u>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DH, HBP, severe anemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>2-3</u> , 19 <u>86</u> , to <u>2-3</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>2-3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Bollino</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2-4-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bollino				22e. ADDRESS 955 Frederick St. Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/6/86		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE LaVale, Allegany, MD	
24. FUNERAL DIRECTOR <u>Harvey H. Zeigler</u> ADDRESS Hyndman, PA 15545				DATE REC'D. BY REGISTRAR FEB 10 1986		25. REGISTRAR'S SIGNATURE <u>Gina Davidson-Pandora</u>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR
Item # 6 G 613
3/21/86 CWSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03287

1. DECEASED NAME (TYPE OR PRINT) James Richard Coleman			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2/6/86, MONTH DAY YEAR			2b. DATE OF DEATH Pronounced DEAD 2/6/86, MONTH DAY YEAR		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 6 1917	6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? usa		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital Cumberland Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Loading		12b. KIND OF BUSINESS OR INDUSTRY Westvaco
13a. STATE West Virginia			13b. COUNTY Mineral		13c. CITY OR TOWN Piedmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Paul A. Coleman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Coleman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2		17. INFORMANT ADDRESS Mrs. Dorothy Coleman Piedmont. W.Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Arterio-sclerotic Heart Disease (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>			TITLE (SPECIFY) Deputy			DATE SIGNED 2/6/86		
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.			ADDRESS 900 Seton Drive, Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/9/86		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.Va.	
24. FUNERAL DIRECTOR NAME Boals Funeral Service			ADDRESS Westernport, Md. 21562			25a. DATE REC'D. BY REGISTRAR FEB 10 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

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NEWMAN FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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1- FOR STATE REGISTRAR
P.O. BOX 267
GRANTSVILLE, MD 21536

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARK EUGENE CRISS			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1986			2b. HOUR 4:40 AM			
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-emp.		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE PA		13b. COUNTY Somerset		13c. CITY OR TOWN Addison		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE (P.O. Box 105) 15411	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Criss				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Flanigan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 174-16-0370		17. INFORMANT ADDRESS Edna Criss, Box 105, Addison, PA 15411			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe CO PD = failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old cell ca.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> OF WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-09-86</u> to <u>2-2-86</u> , that (I) (we) last saw the deceased alive on <u>2-2-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John Mehanne M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-3-86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.					22c. ADDRESS 909-B SETON DRIVE CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Addison, Somerset, PA		
24. FUNERAL DIRECTOR <u>A. Spina Newman</u>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				

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NEW YORK PUBLIC LIBRARY

P.O. BOX 257

GRANTSVILLE, MD 21526

CLARK BEEBE CRIST

FEBRUARY 3, 1988

4:00 P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

114-16-0370

CHIEF OF CLINICAL
COUNSELING, MD 21502

(JOHN M. HENRY)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 8 9

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GILTORY NMN DAVIS			2a. DATE OF DEATH MONTH DAY YEAR February 22, 1986		2b. HOUR 1410 M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1915		
6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.		10. CITY OR TOWN OF DEATH Cumberland		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe Repair		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
14. FATHER'S NAME FIRST MIDDLE LAST James Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Banks		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO. 217-19-1009		17. INFORMANT Louis Redman		18. ADDRESS 217 Carroll Street Cumberland, MD		
18. CAUSE OF DEATH (Enter only one cause per line for all causes) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) _____ Cardiovascular Arrest After respiratory arrest COBD, myeloma ASCD						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) this hospital attended the deceased from Feb 21 1986 to Feb 22 1986 , that (1) (we) lost saw the deceased pass on Feb 21 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)						
22a. SIGNATURE Dr. Terry Williams		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-24-86		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams		22d. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/86		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap Veterans		
23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS Leasure-Stein Funeral Home, Inc. 230 Baltimore Ave. Cumberland, MD 21502				
25a. DATE REC'D. BY REGISTRAR FEB 27 1986		25b. REGISTRAR'S SIGNATURE Felicie Davidson-Randall				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.

REPT MOTION PICT

CHIEF CLERK

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Handwritten notes in cursive script, likely a signature or address, partially obscured by the typed text.

044057

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 9 0

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LILLIAN HITE DAYTON			2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 5, 1986			2b HOUR 1:10P M				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a STATE W. Va.			13b COUNTY Mineral		13c CITY OR TOWN Keyser		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 300 S. Main Street 99999	
FATHER'S NAME FIRST MIDDLE LAST William Reeves Taylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Laurie Hite							
14a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		14b NONE (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. 232-60-5795		17 INFORMANT ADDRESS Montclair, Calif. Mr. Paul T. Dayton, 4805 Harvard St. 91763				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE. DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA. DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks 4 wks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. old age, Congestive Cardiac failure, Cardiac arrhythmias										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Ranjithan				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/7/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN				MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/86		23c. NAME OF CEMETERY OR CREMATORY Queens Rbint Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. Va.				
24a. FUNERAL DIRECTOR Markwood McKenzie Funeral Home, Keyser, W. Va.				24b. DATE REC'D. BY REGISTRAR FEB 10 1986		24c. REGISTRAR'S SIGNATURE Johanna Davidson-Randall				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

04/03/20



050046

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 9 1

REG. NO.

1 DECEASED NAME FIRST MIDDLE LAST VINCENT WILLIAM DENMARK			2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 5, 1986		2b HOUR 1:00P M					
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Nov. 28, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD				
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b KIND OF BUSINESS OR INDUSTRY Paint			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 405 Central Ave. 21502	
14 FATHER'S NAME FIRST MIDDLE LAST Elwood Denmark			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magnolia Cooper							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-7460		17. INFORMANT ADDRESS Charles K. Denmark same as 13a-e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonia, Right Lower Lobe</u>										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>1-29, 1986</u> to <u>2-5, 1986</u> , that (I) (we) last saw the deceased alive on <u>2-5, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2-10-86</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRERA						22e HOSPITAL MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/8/86		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cumberland Alleg.			23d. LOCATION CITY OR TOWN COUNTY STATE MD		
24 FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.						25a DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 14 1986 [Signature]				
230 Baltimore Ave. Cumberland, MD 21502										

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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WIND



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then place in the container for the body. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 0 3 2 9 2			
SILCOX-MERRITT F.H. FOR 1 - STATE REGISTRAR 404 DECATUR STREET CUMBERLANDMD 21502				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MERLE EUGENE DIEHL				2a. DATE OF DEATH MONTH DAY YEAR 02 06 86 2b. HOUR 6:35 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 1 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED U.S. RAILWAY POSTAL SERVICE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE PA.		13b. COUNTY BEDFORD		13c. CITY OR TOWN CENTERVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LLOYD S. DIEHL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL M. CLITES		13e. STREET ADDRESS / ZIP CODE RFD#3 BOX# 633 BEDFORD PA.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W11 220107631		17. INFORMANT JANE DIEHL RFD# 3 BOX# 633 BEDFORD, PA. 15522			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Figueroa</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/8/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. FIGUEROA, M.D.		22e. ADDRESS MEMORIAL MEDICAL BLDG, CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB 9 1986		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CENTERVILLE BEDFORD PA.	
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARY		ADDRESS FEB 11 1986		25a. DATE REC'D. BY REGISTRAR/25b. REGISTRAR'S SIGNATURE John Davidson			

066048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, show any injury, or other traumatic event, the medical examiner must be notified.

DMMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 0 3 2 9 3			
1. STATE REGISTRAR KEYSER, WV 26726				CERTIFICATE OF DEATH			
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA ANN DORSEY				2a. DATE OF DEATH MONTH DAY YEAR FEB 27, 1986		2b. HOUR 3:32P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1934		6. AGE (IN YEARS LAST BIRTHDAY) YRS 51	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PBX Operator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 137 Willow Avenue 99999		14. FATHER'S NAME FIRST MIDDLE LAST Dennis A. Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hallie G. Hoover			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Mr. Robert E. Dorsey, 137 Willow Avenue		ADDRESS Keyser, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Malignant Melanoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. Wagoner</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY L. WAGONER, M.D.		22e. ADDRESS 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/3/86		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W. Va.	
24a. FUNERAL DIRECTOR <i>Markwood Mc Kenzie</i>		ADDRESS Keyser, W. Va.		25a. DATE REC'D. BY REGISTRAR MAR 5 1986		25b. REGISTRAR'S SIGNATURE <i>James W. ...</i>	

MEDICAL CERTIFICATION

685912

WOODWARD STREET HOME
1111 WOODWARD STREET
REVERE, MA 02156

PATRICIA

ALL

DATE

FEB 27 1966

2:30P

ALLEGY

SAVED HEART HOSPITAL



DR. J. W. WALKER, M.D.

205 BISHOP WALSH ROAD CUMBERLAND, MD. 21032

MAR 8 1966

070155

JOHN - KUHLMAN F.H.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 9 4

REG. NO.

1. FOR STATE REGISTRAR 705 MAIN ST.
BERLIN, PA 15530

1. DECEASED NAME (TYPE OR PRINT) FRANK JACOB EMERICK			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1986			2b. HOUR 4:00 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 13 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (GIVE ONLY WORK FOR LAST 12 MONTHS) EQUIP. OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY COAL MINE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PENNA.			13b. CITY OR TOWN SOMERSET		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE GLENCOE R.D.# 1 15543		
14. FATHER'S NAME FIRST MIDDLE LAST WALTER Mc EMERICK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NAOMI M. KENNEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 206-26-7237		17. INFORMANT ADDRESS MRS. DORIS EMERICK R.D.# 1 GLENCOE PA 15543				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>perforated ulcer</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Carcinoma of esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 3 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION 2/21/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>perforated ulcer</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>6/15/83</i> to <i>2/21/86</i> , that (I) (we) last saw the deceased alive on <i>2/21/86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Richard A. Snider</i> DEGREE						22c. DATE SIGNED 2/22/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SNIDER, M.D.						22e. ADDRESS P.O. BOX 2455, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/24/86		23c. NAME OF CEMETERY OR CREMATORY MT LEBANON CEMETERY		23d. LOCATION GLENCOE R.D.#1 COUNTY SOMERSET STATE PA.		
24. FUNERAL DIRECTOR NAME DON NEWMAN						25. DATE REC'D. BY REGISTRAR FEB 28 1986		25. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16-60M 7/84
(VRA 15, 4)

070125

JOHNSTON ROAD
702 MAIN ST.
BERLIN, PA 17330

FRANK JACOB EMERICK
FEBRUARY 21, 1986
6:00 P

1 13 132

ALLEGANY COUNTY

SACRED HEART HOSPITAL

11 11 11

208-26-7317

RECEIVED
NOT
208-26-7317

RECEIVED
FEB 21 1986

CL55

RICHARD SIDER, M.D.
P.O. BOX 2025, CUMBERLAND, MD 21502

180

052195

FOR ZIEGLER FUNERAL HOME
1 - STATE REGISTRAR HYNDMAN, PA. 15545

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 2 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES FRANKLIN EMERICK			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 4, 1986		2b. HOUR 4:00P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11/18/1908		
6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS YRS		8. IF UNDER 24 HRS HOURS MIN. YRS		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		9b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carman		
12b. KIND OF BUSINESS OR INDUSTRY Railroad		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA		13b. COUNTY Bedford		
13c. CITY OR TOWN Hyndman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE R D 1/ 15545 99999		
14. FATHER'S NAME FIRST MIDDLE LAST George W. Emerick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Kennell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 705 09 9001		17. INFORMANT ADDRESS Mary E. Emerick, R D 1, Hyndman, PA 15545		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstr Pulm Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 yr year						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary Embolism anemia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Bruce Behounek		DEGREE Attending Physician		22c. DATE SIGNED 2-6-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE BEHOUNEK, M.D.		22e. ADDRESS BMG 912 SETON DRIVE CUMBERLAND, MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/08/86		23c. NAME OF CEMETERY OR CREMATORY Comps Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE RD, Hyndman, PA, Somerset Cty		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 13 1986 John F. ...				
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, PA 15545						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

03152

RIGHT MARSHAL NOTE
JANUARY 19, 1956

WATER BRANTLEY BRICK FEBRUARY 1956 1:00P

ALLEGANY COUNTY

SACRED HEART HOSPITAL

HOUSE NUMBER 1000 THE 222 EIGHT DRIVE GREENLAND, W. VIRGINIA

057170

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Shaffer Funeral Home STATE OF MARYLAND									
230 E. Main Street DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
Romney, W.V. 26757 CERTIFICATE OF DEATH									
REG. NO. 8 6 0 3 2 9 6									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nora Elizabeth Emswiler					2a. DATE OF DEATH MONTH DAY YEAR February 13, 1986		2b. HOUR 10:30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 13 1917		6. AGE (IN YEARS LAST BIRTHDAY) YRS 68		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE WV		13b. COUNTY Hampshire		13c. CITY OR TOWN Greenspring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. O. Box 84 26722	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Seymore Emswiler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Angie Weymer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234427670		17. INFORMANT ADDRESS W. Frank Emswiler, Box 6, Greenspring, WV					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-13 , 19 86 , to 2-13 , 19 86 , that (I) (we) last saw the deceased alive on 2-13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I was told) (did not) view the body after death.									
22b. SIGNATURE Paul Livengood DEGREE MD				22c. DATE SIGNED 2/14/86				22d. PHYSICIAN'S NAME (TYPE OR PRINT) BMG Paul Livengood M.D.	
22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/15/86		23c. NAME OF CEMETERY OR CREMATORY Omps Cremation Serv.		23d. LOCATION CITY OR TOWN COUNTY STATE Winchester Frederick Va.			
24. FUNERAL DIRECTOR NAME Keith S. Shaffer				25a. DATE REC'D. BY REGISTRAR FEB 19 1986					
24. FUNERAL DIRECTOR ADDRESS Shaffer Funeral Home, Inc. Romney, WV 26757				25b. REGISTRAR'S SIGNATURE Lidia Davidson-Randall					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

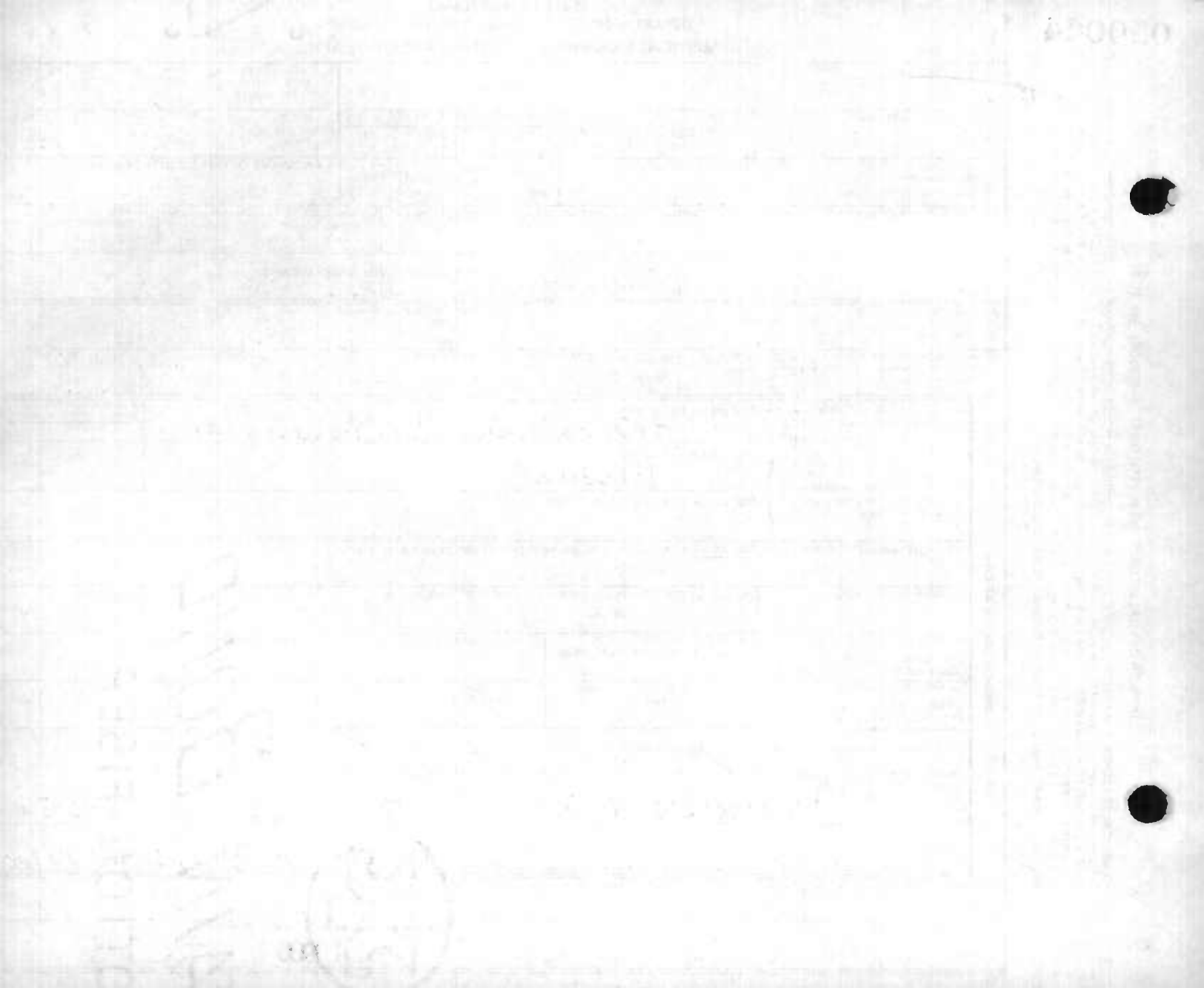
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03297	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Paul Wayne Feters										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Feb. 12 1985	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 4, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Feb. 12 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Moving and Storage Company			
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Corriganville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 140 / 21524	
14. FATHER'S NAME FIRST MIDDLE LAST Howard J. Feters						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Bloss					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-32-2791		17. INFORMANT Delcie Feters				ADDRESS Rt. 1, Box 233 Ridgeley, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francisco Reyes						TITLE (SPECIFY) Deputy		M.D. Deputy		DATE SIGNED 2-12-86	
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes, M.D.						ADDRESS 900 Seton Dr. Cumberland Md 21524					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-16-86		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Meml. Gdns.				23d. LOCATION CITY OR TOWN COUNTY STATE LaVale-Allegany Co.-Maryland	
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.						25a. DATE REC'D. BY REGISTRAR FEB 14 1986		25b. REGISTRAR'S SIGNATURE John Davidson			
202 Greene Street-Cumberland, Md. 21502											

MEDICAL CERTIFICATION



052002

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal team must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 3 2 9 8	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
JOHNNY			GANOE			February 1, 1986			10:29 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
MALE		WHITE		March 22, 1934		51 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
W. Va.		U. S. A.				Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Memorial Hospital				Self		Exterminating			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
W. Va.			Hampshire		Augusta				Star Rt. 2 Box 86E 99999		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Gilbert			Gaoe			Nellie			Starnes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS					
No			228-38-3503			Ilene Gaoe			Augusta, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>liver cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> 19 <u>86</u> , to <u>2-1</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2-1</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Guy Fiscus</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-2-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Guy Fiscus			22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			2-4-86		Church of Christ Memorial Park Delray Hamp.		W. Va.				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Larry S. Miller Romney, W. VA.						FEB 10 1986					

100% COTTON 40/40

CMO

MAINTENANCE



065051

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE CLAIR GRIMES			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1986		2b. HOUR MIN. 1:00P
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 09-15-1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS 1 MONTH 1 DAY
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor		12b. KIND OF BUSINESS OR INDUSTRY railroad
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl A. Grimes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muriel Keller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 215-26-9743		17. INFORMANT ADDRESS Mrs. Marlene Grimes, Cumberland, MD-wife	
18. CAUSE OF DEATH: Enter only one cause per line for each of the following. PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) hypertensive cardiac + renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) hypertension, essential PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:25 Feb 16 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Allegany MD	
22a. I certify that (I) (this hospital) attended the deceased from Feb 14, 1986 to Feb 16, 1986 , that (I) (we) last saw the deceased alive on Feb 14, 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the child died, did not view the body after death.)					
22b. SIGNATURE William W		DEGREE		22c. DATE SIGNED 2-18-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) dr. T. Williams		Memorial Hospital Medical Building Cumberland, Maryland 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-19-1986		23c. NAME OF CEMETERY OR CREMATORY Rocky Gap V/A Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany MD		25a. DATE REC'D. BY REGISTRAR FEB 20 1986			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

FRUIT NOTION CO.

WINTERHILL



071200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 2 and file it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 6 0 3 3 0 0			
FOR BOALS FUNERAL HOME 1- STATE REGISTRAR 111 CHURCH STREET, WESTERNPORT, MD. 21562				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH MONTH DAY YEAR			
FIRST MARY MIDDLE IRONA LAST GROVE				FEBRUARY 17, 1986			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		June 12 1902		83	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		U. S. A.				ALLEGANY COUNTY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Domestic		housewife	
13a STATE				13b CITY OR TOWN		13c STREET ADDRESS / ZIP CODE	
Md.				Allegany		Box 2 Rt 36 Lonaconing Md. 21539	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Horace Michael				Mary Fazenbaker			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
NO		213-74-8134		Richard Grove Westernport Md. 21562			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shock</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>G.I. Bleeding</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		P.M. 19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>8/2/86</u> to <u>2/17/86</u> , that (I) (we) last saw the deceased alive on <u>2/17/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>R. G. Schmitt MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>2/19/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
RICHARD G. SCHMITT, M.D.				900 SETON DRIVE CUMBERLAND, MD. 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN	
Burial		2/20/86		Philos Cemetery		Westernport Allegany Md.	
24 FUNERAL DIRECTOR NAME <u>Boal Funeral Service</u>				25a DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Westernport Md.				FEB 26 1986		<u>John Davidson-Randall</u>	

BP

071300

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070139

FOR SCHAEFFER FUNERAL HOME
1- STATE PETERSBURG, WV
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 0 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EUGENE DEBS HARR			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22, 1986		2b. HOUR 11:43A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 1 14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Electrician		12b. KIND OF BUSINESS OR INDUSTRY IBEW 307
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13c. STATE COUNTY WVa Grant		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Petersburg	13c. STREET ADDRESS / ZIP CODE 112 Mt View St 26847		
14. FATHER'S NAME FIRST MIDDLE LAST John R. Harr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delarie Hanger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-9035	17. INFORMANT ADDRESS Lucille K. Harr 112 Mt View 26847			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-22-86</u> to <u>2-22-86</u> , that (I) (we) lost saw the deceased alive on <u>2-22-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
27b. SIGNATURE <u>Meekama</u>	DEGREE H.D. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-25-86
22b. PHYSICIAN'S NAME (TYPE OR PRINT) BALJEET MAHAL, M.D.	22e. ADDRESS 909-B SETON DR., CUMBERLAND, MD 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-25-86	23c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Lahmansville Grant WVa
24. FUNERAL DIRECTOR NAME <u>Ron Schaeffer</u>		25a. DATE REC'D. BY REGISTRAR MAR 03 1986	
Schaeffer Funeral Home Inc Petersburg, WV 26847		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, was any injury, or other traumatic event, the medical examiner or the medical examiner's representative should be notified.

07-000

RECEIVED
FEBRUARY 22 1980

RECEIVED
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11:47A
FEBRUARY 22 1980

2082 COLLECTION

CHILLMAN



2082 COLLECTION

RECEIVED

RECEIVED
FEBRUARY 22 1980
FEBRUARY 22 1980
FEBRUARY 22 1980

052181

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove and retain page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

SILCOX MERRITT FUNERAL HOME STATE OF MARYLAND									
1. FOR STATE REGISTRAR 404 DECATOR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 8 6 0 3 3 0 2									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLENN REXFORD HAZELTON						2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 4, 1986		2b. HOUR 1:30 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT 15 1901		6. AGE (IN YEARS LAST BIRTHDAY) YRS 84		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RED#5 CUMBERLAND MD. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST RALPH HAZELTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGUERITE BANNING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 178-07-0108		17. INFORMANT CHARLES HAZELTON		ADDRESS 11096 SUNSET STREET LIVONIA, MICHIGAN 48150			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INFERRATERAL MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) LACTIC ACIDOSIS, SEVERE (b) Hypertensive Cardiovascular Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kenneth Zeinkiewicz				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb 4, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH ZEINKIEWICZ, MD				22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB 8 1986		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND			
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MARYLAND				25a. DATE REC'D. BY REGISTRAR FEB 4 3 1986		25b. REGISTRAR'S SIGNATURE Julia K. Anderson-Randall			

027181

CLUB RIFORD HAZELTON FEBRUARY 1, 1986 1:30 A

ALLEGANY COUNTY

SACRED HEART HOSPITAL

X

1 BOWEN TERRACE, MD 405 RIGHT WATER ROAD, CHURCHILL, MD 21503

062091

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 3 3 0 3

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH		DAY	YEAR	2b. HOUR
Mary Frances Helmstetter					2-23-86		2-23-86				2:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR
Female	White	July 19, 1900		85 YRS.					2-23-86		3:40 PM
1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Allegany County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Rt.1 Box 122									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt.1 Box 122		21502	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Frank		Barley		Anna		Lehman		No		213-74-4932	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PART I DEATH WAS CAUSED BY:				ARTERIOSCLEROTIC Heart DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF					
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22. AUTOPSY?					
		HOUR A.M. MONTH DAY YEAR				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED					
ACTUAL SIGNATURE		Giovanni Mastrangelo, M.D.		Deputy		MEDICAL EXAMINER		2/23/86			
EXAMINER'S NAME (TYPE OR PRINT)		Giovanni Mastrangelo, M.D.		ADDRESS		900 Seton Drive, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY	
Burial		2/26/86		SS Peter & Pauls		Cumberland		Allegany		21502 MD	
24. FUNERAL DIRECTOR		NAME		ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leasure-Stein Funeral Home, Inc.		230 Baltimore Ave. Cumberland, MD		21502		FEB 27 1986		Julia Davidson-Randall			

100300

DMR

20% COTTON 2002

MAINTAINED



041135

HAFFER FUNERAL HOME

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 0 4

REG. NO.

1- FOR 1302 NATIONAL HWY.
REGISTRAR LAVALE, MD 21502

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVAN LARUE HIGLEY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1, 1986		2b. HOUR 12:03 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1917		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD			10. CITY OR TOWN OF DEATH Cumberland			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Transport.	
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cresaptown	
14. FATHER'S NAME FIRST MIDDLE LAST Clayton J. Higley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Kilmer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 181-05-0990		17. INFORMANT ADDRESS Teresa E. Higley - same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>2mon</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>86</u> , to <u>2/1</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS BMG, 912 SETON DRIVE CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 4, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gar. LaVale, Allegany, MD		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR				
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. LaVale, MD 21502		25. REGISTRAR'S SIGNATURE FEB 06 1986 <u>[Signature]</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

041152

WATER PLANT L. 1002
NATIONAL H. Y.
LAVALE, MD 21502

12:05P FEBRUARY 1, 1988 EVAN LARINE HIGHLY

Who Date June 22, 1987

ALLEGANY COUNTY

Westinghouse

SACRED HEART HOSPITAL

Chamberland

Arnold Drive / 21502

Allegany Westinghouse

Miller

June

Hi Day

London

131-63-0920 Tel. 131-63-0920 - same as above

ONE, 215 SETON DRIVE
CHAMBERLAND, MD 21502

Initial Feb. 4, 1988 Westinghouse, Tel. 131-63-0920, MD

John L. Hester, Jr. Lavale, MD 21502 Tel. 131-63-0920

070129

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
Bernadette ALTA Hinkle			02 23 86			8:45 P.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.	
FEMALE	WHITE	MAY 17 1895		90 YRS.		MONTHS DAYS		HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH					
WEST VIRGINIA		USA		Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Cumberland		Lions Manor Nursing Home				12b. KIND OF BUSINESS OR INDUSTRY RETIRED REGISTERED NURSE			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MARYLAND			ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE			
DENNIS A. WILSON			ALICE MIDDLETON			RFD# 2 BALTIMORE PIKE 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
NO			215-36-9683			LINDA CARPENTER PO BOX 23 CORRIGANVILLE MD.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio U. T. I. (Urinary tract infection)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dehydration, Severe mental depression</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>12-31</u> , 19 <u>85</u> , to <u>2-23</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>2-21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>V.A. Ranjithan</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2-24-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.						22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			FEB 26 1986		MT. PLEASANT CEMETERY		CUMBERLAND ALLEGANY MARYLAND		
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND						25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						FEB 28 1986		<u>[Signature]</u>	

MEDICAL CERTIFICATION

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic result, the medical examiner must be notified at once.

BP

051070

100% COTTON

MADE IN ITALY



052156

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 3 3 0 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ROSELEN H HOCHARD			February 2, 1986			7:31 P. M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
F	WHITE	5 14 25	60 YRS			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (COUNTY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Frostburg, MD	USA		Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Memorial Hospital						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN		
MD			GARETT			FROSTBURG		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS / ZIP CODE		
WILLIAM J HUGHES			MARGARET BOND HUGHES			RT. 2 Box 440 21532		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				
NO		215-20-5123		HUSBAND GEORGE HOCHARD, RT 2 BOX 440 FROSTBURG, MD 21532				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) SEPTIC SHOCK.								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) g-v septicemia								
DUE TO, OR AS A CONSEQUENCE OF								
(c) PERITONITIS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
chronic renal failure, peripheral diabetes, Diabetes, malnutrition.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Ranjithan				DEGREE MD			22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			2/4/86	
22d. PHYSICIAN'S NAME (PRINT OR PRINT)				22e. ADDRESS				
Dr. Ranjithan				Memorial Hospital Med. Bldg., Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		2/5/86		FROSTBURG MEMORIAL		FROSTBURG ALLEGANY MD		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOWERS FUNERAL HOME 60 W. Main St FROSTBURG, MD 21532				FEB 4 1986		Julia Davidson-Randall		

BP _____

B

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6-11-59

RECEIVED MOTOR CO

COMMERCIAL AIRCRAFT CO



1-1-59

066110

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 0 7

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred V. Hott			2a DATE OF DEATH MONTH DAY YEAR February 18 1986		2b HOUR 9:30 PM
3 SEX MALE	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 10 23 02		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10 CITY OR TOWN OF DEATH Frostburg	11 NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Village Nursing Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TIKE BUILDER	12b KIND OF BUSINESS OR INDUSTRY TIKE Co.
13a STATE MD		13b COUNTY Allegheny	13c CITY OR TOWN Frostburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Frostburg, Md. 21532
14 FATHER'S NAME FIRST MIDDLE LAST William Hott		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Hooten			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-07-0780		17 INFORMANT ADDRESS Dolores K. Morgan Frostburg, Md. 21532	
18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF, (b) Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF, (c) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary Artery Disease, Pneumonia					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Dec 24 1985 to Feb 18 1986 , that (I) (we) last saw the deceased alive on Feb 18 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE Charles H. OH. MD		DEGREE MD		22c DATE SIGNED 2-20-86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CHAS. H. OH. MD		22e ADDRESS 48 TARN TERRACE, FROSTBURG, MD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL	FEB. 20 1986	FROSTBURG MEMORIAL		FROSTBURG ALLEGANY MD.	
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25 DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE	
DURST FUNERAL HOME		FROSTBURG, MD.		FEB 25 1986 John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. This certificate is to be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a medical examination should be made.

BP

1. The first part of the report is a general statement of the work done during the year.

2. The second part is a detailed account of the work done in each of the various branches of the service.

3. The third part is a summary of the results of the work done during the year.

4. The fourth part is a statement of the financial position of the service at the end of the year.

5. The fifth part is a statement of the progress made during the year in the various branches of the service.

6. The sixth part is a statement of the progress made during the year in the various branches of the service.

7. The seventh part is a statement of the progress made during the year in the various branches of the service.

8. The eighth part is a statement of the progress made during the year in the various branches of the service.

9. The ninth part is a statement of the progress made during the year in the various branches of the service.

10. The tenth part is a statement of the progress made during the year in the various branches of the service.

11. The eleventh part is a statement of the progress made during the year in the various branches of the service.

12. The twelfth part is a statement of the progress made during the year in the various branches of the service.

13. The thirteenth part is a statement of the progress made during the year in the various branches of the service.

14. The fourteenth part is a statement of the progress made during the year in the various branches of the service.

15. The fifteenth part is a statement of the progress made during the year in the various branches of the service.

16. The sixteenth part is a statement of the progress made during the year in the various branches of the service.

17. The seventeenth part is a statement of the progress made during the year in the various branches of the service.

18. The eighteenth part is a statement of the progress made during the year in the various branches of the service.

052133

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 0 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN JOSEPH HUMBERTSON			2a. DATE OF DEATH MONTH DAY YEAR 02 10 86		2b. HOUR 16:09 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH YEAR MONTH DAY 05TH 12TH 14	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY textile	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY ALLEG	13c. CITY OR TOWN FLINTSTONE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 2 / 21530	
14. FATHER'S NAME FIRST MIDDLE LAST George Humbertson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Sieb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 214-07-3460	17. INFORMANT ADDRESS Mrs. Beulah Humbertson, Flintstone, MD - wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ranjithan</i>		DEGREE MD		22c. DATE SIGNED 2/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ranjithan		22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 02-13-1986	23c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany Md	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR 2-14-1986		25b. REGISTRAR'S SIGNATURE <i>John F. ...</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a certifying physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please inform early papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

000103

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MEMORIAL HOSPITAL 02 15 11 02 15 11 02 15 11

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CHIEF EXAM BOARD

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 6 0 3 3 0 9

EICHORN FUNERAL HOME

REGISTRAR MAIN ST. LONA CONING, MD. 21539

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL N. HUTCHESON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 7, 1986		2b. HOUR 6:10AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR OCT 15, 1910		6 AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD Allegany Lonaconing		13b. CITY OR TOWN Lonaconing		13c. STREET ADDRESS / ZIP CODE 93 Douglas Avenue		
14 FATHER'S NAME David Clark Preston			15 MOTHER'S MAIDEN NAME Bertha Frenzel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Wm. J. Hutcheson		ADDRESS 93 Douglas Ave, Lonaconing, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Fracture left hip						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan 30 19 86 , to Feb. 7 19 86 , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Richard Johnson M.D.				DEGREE M.D.		22c. DATE SIGNED 2/12/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD JOHNSON, M.D.				22e. ADDRESS 122 S. CENTRE STREET CUMBERLAND, MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-9-86		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION Moscow Allegany Md STATE
24. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md.				25a. DATE REC'D. BY REGISTRAR FEB 14 1986		25b. REGISTRAR'S SIGNATURE L. G. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

020013

ELIZABETH FUNERAL HOME
MAIN ST. LONGMONT, CO. 1125

ETHEL MACY HUTCHESON
FEBRUARY 7, 1988 4:10

ALLEGANY COUNTY

SACRED HEART HOSPITAL

ALLEGANY HOSPITAL

ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

to none

620-674-1118

ALLEGANY COUNTY

x

123 S. CENTRE STREET CANTON, OH 44703

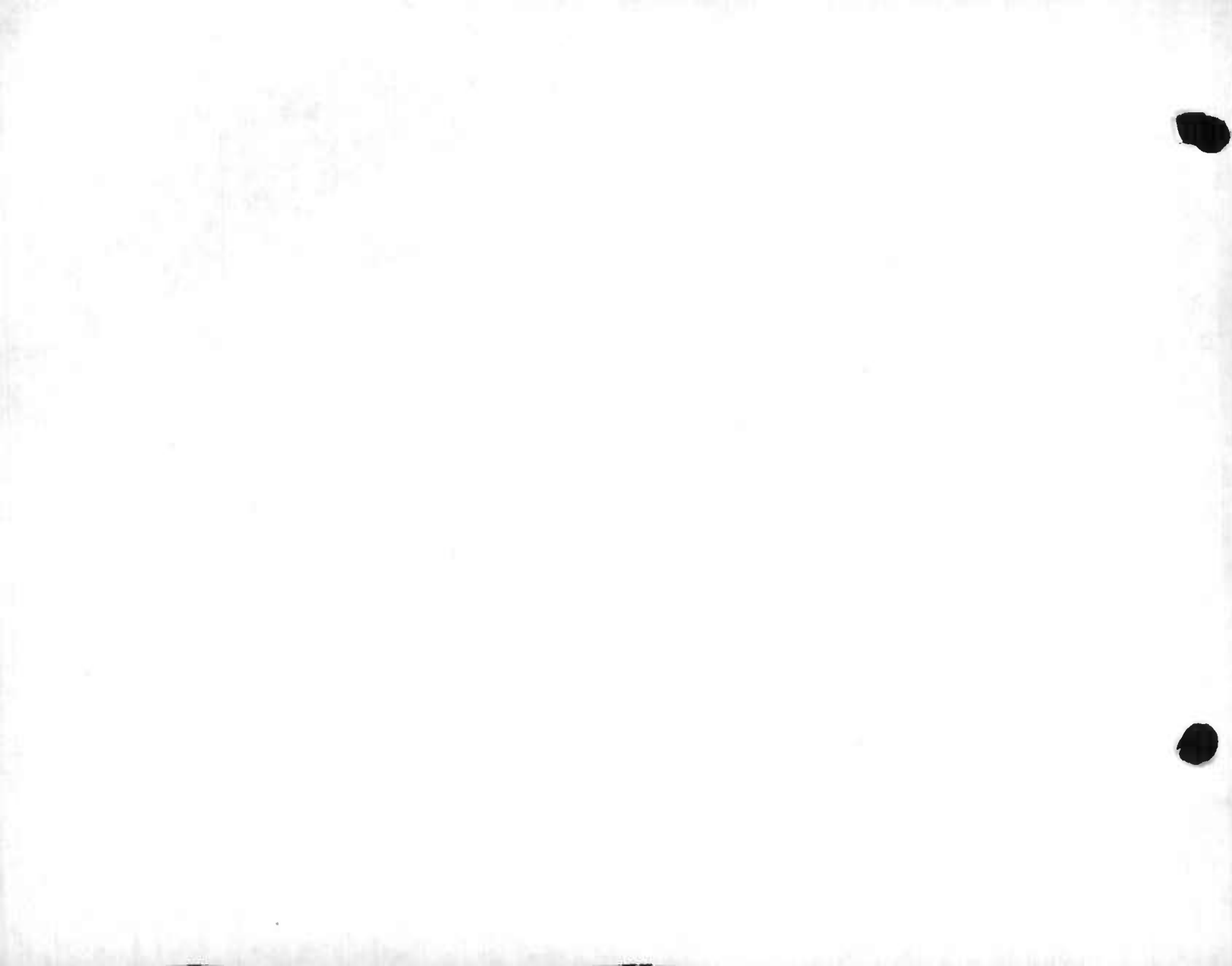
RICHARD J. HUTCHESON, M.D.

ALLEGANY COUNTY

ALLEGANY COUNTY

VOID

CERT. # 86-03310



065160

DURST FUNERAL HOME
57 FROST AVE.,
FROSTBURG, MD 21532

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 1 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN HENRY JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 19, 1986		2b. HOUR 9:15 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1901		
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		
12b. KIND OF BUSINESS OR INDUSTRY Coal Mines		13a. STREET ADDRESS / ZIP CODE 30 Hill St., 21532		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Baker Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Bittinger		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 216-03-8551		17. INFORMANT ADDRESS Mae R. Johnson, Same as 13e		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PURULENT BRONCHITIS DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE DEGREE SUSAN SCHWARTZ MD		22c. DATE SIGNED 2/19/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) FROSTBURG PLAZA, FROSTBURG, MD 21532		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 22 '86		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Feb 25 1986 John Davidson-Randall				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove color paper. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

062310

QUEST FISCAL TIME
ST. PETERS, MO. 63103
BETTER, N. 2122

FERRY JOHNSON FEBRUARY 19, 1958 9:15 A

1000

ALLEGANY COUNTY

BACKED HEART HOSPITAL

Johnson

NOTICE

WITNESS



PROSTATE PLAZA, BROOKLYN, MO 63103

ST. PETERS, MO 63103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

056021

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8603312			
1. FOR STATE REGISTRY 11 MINERAL STREET KEYSER, WA 26726				2a. DATE OF DEATH FEBRUARY 17, 1986			
1. DECEASED NAME (TYPE OR PRINT) VIRGINIA ELIZABETH JOHNSON				2b. HOUR 9:55 AM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH March 16, 1921		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY College	
13a. STATE W. Va.		13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jay Evers Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie -- Stump		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Westernport, Md. Mr. Franklin S. Johnson 141 Church St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver & lung failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ce of heart = Refers last.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>to liver - Bone - Bone marrow</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>CONTRIBUTING TO DEATH</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-15-1986</u> to <u>2-17-1986</u> that (I) (we) lost saw the deceased alive on <u>2-17-1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Mehan</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-17-86	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, MD		23b. ADDRESS 909-B STEON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Levels, Hampshire W. Va.	
23e. FUNERAL HOME Hawthorn W. McKenzie		23f. ADDRESS Keyser, W. Va.		23g. BY <u>EEB21</u> 1986			

ISO 9000

3891 J. C. CALVERT

YOUNG MANGLIA

071189

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 3 3 1 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Violet R. Jones			2a. DATE OF DEATH MONTH DAY YEAR Feb. 21, 1986			2b. HOUR 9 A M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 8, Country Club Road 21502	
14. FATHER'S NAME FIRST MIDDLE LAST John Brehm				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Cope					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-54-9835		17. INFORMANT ADDRESS Vincent & Clarence Jones, Cumberland, Sons			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiomyopathy, Arteriosclerosis, CHF + CAD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD (c) ASCVD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Operative									
19a. DATE OF OPERATION Jan 18 86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHF + CAD			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE Mem 27 74 Feb. 21 86			
22. I certify that (1) (this hospital) and (2) the cause of death from Jan 18 86 to Feb. 21 86 , that (1) (we) lost saw (1) deceased alive on Jan 18 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22a. SIGNATURE Terry E. Williams						DEGREE MD		22c. DATE SIGNED 2-24-1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Terry E. Williams MD						22e. ADDRESS Memorial Hospital, Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-24-1986		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli ADDRESS Cumberland, Md. 21502						25a. DATE REC'D. BY REGISTRAR Feb 26 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, page 3, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be contacted at once.)

BP

DATE: 10/10/68

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]



050163

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		SCARPELLI FUNERAL HOME 108 VIRGINIA AVE. CUMBERLAND, MD 21502		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 0 3 3 1 4		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) STELMAN STERLING KERNS				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 7, 1986		2b. HOUR 7:45 PM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 04-27-1908		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY textile	
13a STATE MD		13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Route 8/21502	
14 FATHER'S NAME FIRST MIDDLE LAST Luther Winfield Kerns				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zoey Warner					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-4466		17. INFORMANT ADDRESS Mrs. Pansy L. Kerns, Cumberland, MD - wife					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CA of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Qamar Zaman</u> (N.A. Kanjithan M.D.)				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) QAMAR ZAMAN, M.D.				22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-10-1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24 FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

FEB 13 1986

027163

SCOTT'S FURNACE
100 WEST 11th AVE.
CHICAGO, ILL. 60605

STEVENS STERLING 1892

FEBRUARY 7, 1892

ALFRED G. COLBY

SACRED HEART HOSPITAL

21X-10-0000

CHICAGO, ILL. 60605
SCOTT'S FURNACE

(NAME SWAMP, ILL.)

044054

FOR STATE REGISTRAR
202 Greene Street
Cumberland, MD 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mida Pearl Kesecker			2a. DATE OF DEATH MONTH DAY YEAR February 2, 1986		2b. HOUR 12:40AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 7, 1904		
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. UNDER 1 YEAR MONTHS DAYS 81		8. UNDER 24 HRS. HOURS MIN. 81		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS / ZIP CODE 107 Wilmont Ave. / 21502		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13c. CITY OR TOWN Allegany		13d. STATE Maryland		13e. COUNTY Cumberland		
14. FATHER'S NAME FIRST MIDDLE LAST Austin Flint Somers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no -		
16b. SOCIAL SECURITY NO. 183442072		17. INFORMANT Joseph Kesecker, Jr.-Address same as #13.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 1/80 , 19 86 , to 2/2 , 19 86 , that (I) (we) last saw the deceased alive on 2/3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Wayne Spizzle		
22c. DATE SIGNED 2/3/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne Spizzle		22e. ADDRESS BMG, 192 Seton Drive, Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 2-4-86		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-MD.		24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.		25a. DATE REC'D. BY REGISTRAR FEB 10 1986		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

Intervall: zwei Formen?

070175

NEWMAN FUNERAL HOME

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 1 6

1 - STATE REGISTRAR P. O. BOX 267
GRANTSVILLE, MD 21536

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLADYS IRENE KIDD			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1986		2b. HOUR 10:00AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 4, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sherman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Kelly		13e. STREET ADDRESS / ZIP CODE Rural Route (P.O. Box 73) 21531			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-18-6001		17. INFORMANT ADDRESS P.O. Box 73 Mrs. Ireta Gittere, Friendsville, MD 21531			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus, arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George Newman</u> MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/22/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BMG		22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-23-86		23c. NAME OF CEMETERY OR CREMATORY Friend Family Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, MD	
24. FUNERAL DIRECTOR NAME <u>George Newman</u>		ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR MAR 03 1986		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be detached with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, also notify injury, or other traumatic event, the medical examiner with the vital and records.

BP

0770172

NEWSPRINT PUBLISHED WEEKLY
F. O. BOX 285
CLINTON, ILL. MO. 62426

10:00P FEBRUARY 21 1988

CLAYTON IRVING KING

ALLICANY

SAVED FROM DEBT

225-18-6001

FOR SETTING THE COVERLAND IN 21203

070128

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 1 7

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) VIRGINIA M. KNIPPENBERG			2a. DATE OF DEATH MONTH DAY YEAR February 21, 1986			2b. HOUR 10:45 a.m.			
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-19-1914		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Co-Owner		12b. KIND OF BUSINESS OR INDUSTRY Bakery	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 4-Oldtown Road/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Frantz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Holzen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-7436		17. INFORMANT ADDRESS John, Stephen & Robert Knippenberg - sons					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) BRASILAR PNEUMONIA PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC BRONCHITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:15 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) this hospital attended the deceased from 2/21/86 to 2/21/86 , that (II) (we) last saw the deceased alive on 2/21/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did, did not, view the body after death.									
23a. SIGNATURE Dr. Sahn Nathan			23b. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			23c. DATE SIGNED 2/23/86		23d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-23-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR FEB 28 1986			
25b. REGISTRAR'S SIGNATURE J. F. Scarpelli									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



ONE

WALKER

NOTICE

STOP

100

100

100

100

052067

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. THIS CERTIFICATE IS TO BE FORWARDED TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 0 3 3 1 8

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Edward Kreyer			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-15-1986 MONTH DAY YEAR		2b. HOUR 4:4 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 16 1920 65 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 2 15-1986 MONTH DAY YEAR	2d. HOUR 11:2 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY		MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROUTE 8 VALLEY ROAD-BOWMANS ADDITION RETIRED CELANESE CORP. SILK		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21502	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL B. KREGER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES ELIZABETH LINGENFIELD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219-03-9412		17. INFORMANT ADDRESS MRS FRANK RATKE 26 MCKENZIE ROAD LAVALE MD.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <u>Francisco Reyes</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED 2-15-86
EXAMINER'S NAME (TYPE OR PRINT) <u>Francisco Reyes</u>		ADDRESS <u>900 Sothn Dr. Cumberland Md.</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB 18 1986	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		DATE REC'D BY REGISTRAR AND REGISTRAR'S SIGNATURE FEB 18 1986 <u>J. H. Anderson</u>	

1917. 1918.

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070131

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

FOR SHAFTERS FUNERAL HOME				STATE OF MARYLAND			
1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
230 E. MAIN ST. ROMNEY WV				CERTIFICATE OF DEATH			
REG. NO.				8603319			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH			
ELMA VIRGINIA LAMBERT				FEBRUARY 25, 1986			
3 SEX				4 RACE			
Female				White			
5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)			
July 3 1919				66			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?			
West Virginia				U.S.A.			
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
				ALLEGANY COUNTY MD.			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Cumberland				SACRED HEART HOSPITAL			
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				12b KIND OF BUSINESS OR INDUSTRY			
Housewife				Home			
13a STATE				13b COUNTY			
WV				Hampshire			
13c CITY OR TOWN				13d INSIDE CITY LIMITS?			
Levels				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e STREET ADDRESS / ZIP CODE				13f STREET ADDRESS / ZIP CODE			
Star Rt. Box 50				25431			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Daniel B. Harper				Anzina Vandevender			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.			
No				232-66-4445			
17 INFORMANT				ADDRESS			
James M. Lambert				Star Rt. Box 50, Levels, WV			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <i>End stage metastatic papillary adenocarcinoma</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (b) <i></i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i></i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>							
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a AUTOPSY?				20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)				21b TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d INJURY OCCURRED				21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK							
21f LOCATION				CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost							
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE				22c DATE SIGNED			
<i>Gary L. Wagoner</i>				2/26/86			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
GARY L. WAGONER, M.D.				925 BISHOP WALSH RD. CUMBERLAND, MD. 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE			
Burial				2/28/86			
23c NAME OF CEMETERY OR CREMATORY				23d LOCATION			
Wesley Chapel Cemetery				CITY OR TOWN COUNTY STATE			
Points				Hampshire WV			
24 FUNERAL DIRECTOR				25a DATE REC'D. BY REGISTRAR			
Keith S. Shaffer				WV			
Shaffer Funeral Home, 230 East Main St., Romney				25b REGISTRAR'S SIGNATURE			

07/07/12

ELIZABETH VIRGINIA FEBRUARY 23, 1882

ALLSOUTH COUNTY

CHARLES HENRY HARTMAN



THE J. H. HARTMAN, JR. COMPANY, NEW YORK

044058

George-Upchurch Funeral Home, P.A. STATE OF MARYLAND

202 Greene Street DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Cumberland, MD 21502 CERTIFICATE OF DEATH

8 6 0 3 3 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mason Burr Lease			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1986		2b. HOUR 12:01A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Ruben Burr Lease			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie - Lease		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Rt. 3, Box 278L Rawlings, Md 21557	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAD & arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-50</u> , 19 <u>85</u> , to <u>2-7</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>2-6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Uriel Velandia</u>		DEGREE		22c. DATE SIGNED 2-6-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Uriel Velandia, M.D.		22e. ADDRESS 924 Seton Drive, Cumberland MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-8-86	23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Meml. Gdns.	23d. LOCATION CITY OR TOWN COUNTY STATE LaVale - Allegany Co.-Md.
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR FEB 10 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

014052

George Washington University
202 K Street
Washington, D.C. 20037

March 1962 1962 1962 1962 1962 1962 1962 1962 1962 1962

Allegany County

General Health Hospital

21104722

George Washington University

United Volunteers, N.Y.

202 K Street, Washington, D.C. 20037

057168

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (15))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03321	
1. DECEASED NAME (TYPE OR PRINT) ALLEN EDWARD LEWIS							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 2 15 1986		2b. HOUR OF DEATH 2:00 PM		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 20 25		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 2-15-1986		2d. HOUR 2:00 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) disabled		12b. KIND OF BUSINESS OR INDUSTRY ***			
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumb.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 5, WE-17 Cumberland.			
14. FATHER'S NAME FIRST MIDDLE LAST ALLEN LEWIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BLACK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 218-16-3723		17. INFORMANT ADDRESS DONNA JEAN KETTERMAN, RAWLINGS, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible Myocardial Infarction.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Francisco Reyes</i>			TITLE (SPECIFY) <i>Deputy</i>			M.D. MEDICAL EXAMINER		DATE SIGNED 2-15-86			
EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes			ADDRESS 900 Seton Dr. Cumberland, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/18/86		23c. NAME OF CEMETERY OR CREMATORY ROCKY GAP VA CEM			23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MD				
24. FUNERAL HOME SOWERS FUNERAL HOME			60 W. MAIN ST. FROSTBURG		DATE REC'D. BY REGISTRAR FEB 19 1986		25. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>				

MEDICAL CERTIFICATION

03718

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-00 BY 60323

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-00 BY 60323

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DATE 10-10-00 BY 60323

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-00 BY 60323

Scarpelli

066112

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 2 2

REG. NO.

1 - FOR STATE REGISTER		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P. M.			
FIRST MARY		MIDDLE CECELIA		LAST LITTLE		February 18, 1986		6:35	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-21-1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 516 Fort Avenue/21502	
14. FATHER'S NAME FIRST MIDDLE LAST John Pollock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Blank							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Mr. John H. Little, Cresaptown, MD - son					
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> , 19 <u>86</u> , to <u>2-18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>William P. James MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/20/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William P. James		22e. ADDRESS 441 North Centre Street Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-21-1986		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>		FEB 24 1986			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 2 3

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH K. LOWERY			2a. DATE OF DEATH MONTH 02 DAY 15 YEAR 86			2b. HOUR 3:58 PM					
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		7. IF UNDER 1 YEAR MONTHS 02 DAYS 15		8. IF UNDER 24 HRS HOURS 03 MIN. 23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Allegany 13c. CITY OR TOWN ELLERSLIE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE PO BOX 315/21529											
14. FATHER'S NAME FIRST Charles MIDDLE Newcomer LAST Smith				15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Smith LAST Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 196 14 6762				17. INFORMANT ADDRESS MD 21502 Glenn Stahlman, Box 121B, RT 1, Cumberland,			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **Probable CHF and**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Coronary Artery Disease**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Don't Injury			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 86 to only 19 86 that (I) (we) last saw the deceased alive on 2/15 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John C. Stansbury MD				DEGREE MD		22c. DATE SIGNED 2/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Stansbury MD				22e. ADDRESS Memorial Hosp. Cumberland Md 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/86		23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		23d. LOCATION CITY OR TOWN RD, Hyndman, Bedford, PA COUNTY STATE	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, PA 15545				25. DATE REC'D BY REGISTRAR FEB 18 1986 26. REGISTRAR'S SIGNATURE Lelia Davidson-Randall			

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on Item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 3 3 2 4

1. DECEASED NAME (TYPE OR PRINT) Juanita C. Lutz			2a. DATE OF DEATH MONTH February DAY 18 YEAR 1986			2b. HOUR M						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 1929		6 AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? usa		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County			MD			
10. CITY OR TOWN OF DEATH Pekin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 36 Pekin, Md. 21546				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress			12b. KIND OF BUSINESS OR INDUSTRY Rest.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Nikep		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 36 21546		
14. FATHER'S NAME FIRST Joseph MIDDLE LAST Droll				15. MOTHER'S MAIDEN NAME FIRST Julia MIDDLE Kifer LAST 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-24-7928		17. INFORMANT ADDRESS Mr. Roy Droll Rt. 36 Nikep Md. 21546						
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF: (c) Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from Jan 12 1986 , to Feb 12 1986 , that (I) (we) last saw the deceased alive on Jan 12 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
23a. SIGNATURE Charles H. Johnson MD				DEGREE MD				23b. DATE SIGNED 2/21/86				
23c. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES H. JOHNSON MD				23d. ADDRESS SPAWN TERRACE ROSBURG MD								
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23f. DATE 2/20/86		23g. NAME OF CEMETERY OR CREMATORY Bloomington Cemetery		23h. LOCATION CITY OR TOWN Bloomington COUNTY Garrett STATE Maryland				
24. FUNERAL DIRECTOR NAME Boal Funeral Service ADDRESS Westport Md.				25a. DATE REC'D. BY REGISTRAR FEB 26 1986				25b. REGISTRAR'S SIGNATURE Wanda Anderson				

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

066106

STATE OF MARYLAND FOR SCARPELLI FUNERAL HOME DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1. STATE REGISTRAR 108 VA. AVE. CUMB.MD. CERTIFICATE OF DEATH										8 6 0 3 3 2 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE B. MACMILLAN						2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 24, 1986				2b. HOUR 8:30P ^M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09-24-1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. Secretary		12b. KIND OF BUSINESS OR INDUSTRY Gas Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 936 Seton Drive/21502					
14. FATHER'S NAME FIRST MIDDLE LAST James J. Burns Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Eichorn									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215122132		17. INFORMANT ADDRESS Mr. James J. Burns, Jr. - Cumberland, MD 21502							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Breast with</i> DUE TO, OR AS A CONSEQUENCE OF <i>Diffuse metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 years from diagnosis</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/6/79</i> , to <i>2/5/86</i> , that (I) (we) lost saw the deceased alive on <i>2/24</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DEGREE BMG <i>[Signature]</i>						22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BMG <i>[Signature]</i>						22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 02-27-1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502						25. DATE REC'D. BY REGISTRAR FEB 28 1986 <i>[Signature]</i>							

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2002 FEBRUARY 10
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RECEIVED D. H. HILL

FEBRUARY 10, 2002

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ALLEGANY COUNTY

COUNTY HEALTH DEPARTMENT

PERMISSION

013 DATA DRIVE CHARTERS, MT. 21002

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXAMINE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL- TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										0 3 3 2 0			
1. DECEASED NAME (TYPE OR PRINT) AUBREY DENVER MAUZY										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 12 86										2b. HOUR OF DEATH 1200 Noon			
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 5 09 09		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 12 86		7d. HOUR 1715 M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD											
10. CITY OR TOWN OF DEATH Flintstone				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 1 Flintstone				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter				12b. KIND OF BUSINESS OR INDUSTRY Carpentry											
13a. STATE Maryland										13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 21530							
14. FATHER'S NAME FIRST MIDDLE LAST Saul P. Mauzy										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude V. Mallow													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WWII 214-07-1141		17. INFORMANT Box 630 ADDRESS Martha Mauzy Mt. SAVAGE, MD. 21545																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF, Acute congestive heart failure (b) } DUE TO, OR AS A CONSEQUENCE OF, Arteriosclerotic heart disease (c) }														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hours 1 day yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Diabetes;																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Paul Snow, M.D.						TITLE (SPECIFY) Dpty						MEDICAL EXAMINER DATE SIGNED 2-12-86											
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D. Memorial Hospital, Cumberland Md ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-15-86		23c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany Maryland													
24. FUNERAL DIRECTOR NAME ADDRESS Silcox-Merriett 404 Decatur St. Cumb. Md. 21502										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									

07/B4
25M

BP_____

DHMH - 17

(VR A15 ME (5))

025012

END

100%

REPLACEMENT



052062

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. FOR STATE REGISTRAR					8 6 0 3 3 2 7							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel P. May					2a DATE OF DEATH MONTH DAY YEAR 02 04 86			2b HOUR P. M. 2:45 P.				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 07/26/08		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.						
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) patient care		12b KIND OF BUSINESS OR INDUSTRY nursing home				
13a STATE MD					13b COUNTY Allegany		13c CITY OR TOWN Corriganville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 21524	
14 FATHER'S NAME FIRST MIDDLE LAST Emerenth May					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Corley							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. 215 36 9669		17 INFORMANT ADDRESS Mary E. Turner, Corriganville, MD 21524						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra abdominal carcinoma metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>C.A.D., Arteric Stenosis, C.V.A.</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>86</u> , to <u>2-4</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE V.A. Ranjithan				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-5-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.				22e. ADDRESS Lions Manor N. H. Seton Dr. Cumberland, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 02/07/86		23c. NAME OF CEMETERY OR CREMATORY Dry Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE RD, Buffalo Mills, Bedford, PA				
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, PA				ADDRESS 15545		25a. DATE REC'D. BY REGISTRAR FEB 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP

STAIN NO. 005005

CHERRYMAN BENT



070156

FOR STATE REGISTRATION
 85 S. MAIN STREET
 KEYSER, WVA 26726

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8603328
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BRYAN NMI MCCLLOUD				FEBRUARY 22, 1986		8:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Aug. 7, 1901		84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		U.S.A.				ALLEGANY COUNTY MD.	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		SACRED HEART HOSPITAL		Trackman		Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
W. Va.		Mineral		Keyser		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
John - McCloud		Mary J. Poland		No		232 26 0247	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Mary McCloud Rt 1 Box 69 Keyser, W. Va.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE		ONE HOUR			
		DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA, INTERSTITIAL PULMONARY FIBROSIS		ONE MONTH			
		DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ATRIAL FIBRILATION CHRONIC BRAIN SYNDROME					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		19 P.M.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/21/86 to 2/22/86, that (I) (we) last saw the deceased alive on 2/21/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
		MD				2/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
ARVIND PATHAK, MD		913 SETON DRIVE, CUMBERLAND, MD 21502		Burial		25 Feb 1986	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Queen Point		Keyser Mineral W. VA.		ALLEN ROTRUCK KEYSER, W. VA.		25b. REGISTRAR'S SIGNATURE	
						MAR 03 1986	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this page to the funeral director. Page 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

050162

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must use method of ruling.

SCARPELLI FUNERAL HOME

STATE OF MARYLAND

1 - STATE
REGISTRAR

108 VIRGINIA AVENUE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CUMBERLAND, MD 21502

CERTIFICATE OF DEATH

REG. NO.

8 6 0 3 3 2 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA PAULINE MCCOY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1986		2b. HOUR 4:15 AM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-09-1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE WV		13b. COUNTY Mineral		13c. CITY OR TOWN Fort Ashby		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE none/26719 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob A. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audrey K. Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-58-0471		17. INFORMANT ADDRESS Mr. Evers A. McCoy, Fort Ashby, WV - husband					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anteriorseptal Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/2/86</u> 19 <u>86</u> to <u>2/3/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/2/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. Scarpelli				22e. ADDRESS BMG, 912 SETON DRIVE CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-05-1986		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Ashby Mineral WV			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR FEB 10 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

000125

ROBERT B. BROWN
108 VIRGINIA AVENUE
CONVENT, N. CAROLINA

AND ELLIOTT MOODY

FEBRUARY 25, 1968

4-32 A

WILHELM COUNTY

CHERRY HILL HOSPITAL

100-24-0071

ONE, 212 GLENN DRIVE
CONVENT, N. CAROLINA

052142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 3 0

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) REFORD CHARLES McKENZIE			2a DATE OF DEATH MONTH DAY YEAR February 7, 1986			2b HOUR 4:00 P. M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Textile	
12b KIND OF BUSINESS OR INDUSTRY Celanese							
13a STATE Maryland				13b CITY OR TOWN Allegany Mt. Savage		13c STREET ADDRESS / ZIP CODE 103 Columbia Ave., 21545	
14 FATHER'S NAME FIRST MIDDLE LAST Elmer C. Mc Kenzie				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Poorbaugh			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2		17 INFORMANT ADDRESS P.O. Box 186 Cherie De Haven, Corriganville, Md.			

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Diabetes insipidus

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

Metastatic prostate CA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>H. Merrick</i>				DEGREE		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Merrick				22e ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Feb. 10 '86		23c NAME OF CEMETERY OR CREMATORY St. Patrick Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Md.	
24 FUNERAL DIRECTOR NAME ADDRESS Drst Funeral Home, Frostburg, Md.				25a DATE RECD. BY REGISTRAR FEB 14 1986		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

1311530

OF

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SILCOX-MERRITT F.H. DEPARTMENT OF HEALTH AND MENTAL HYGIENE				STATE OF MARYLAND			
1. FOR STATE REGISTRAR 404 Decatur St Cumberland, MD 21502				21502 CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Earl McNeel				2a. DATE OF DEATH MONTH DAY YEAR February 20, 1986			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 2 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 60	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HAVANA, CUBA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany county, MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER SPORETS GARAGE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. CITY OR TOWN ALLEGANY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE MARTZ LANE 21502	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY EARL MCNEEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MOORE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII			
16b. SOCIAL SECURITY NO. 246229857		17. INFORMANT ADDRESS CATHERINE MCNEEL MARTZ LANE LAVALE MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostate Artery MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>3 h</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral aneurysm; arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>19 Jan</u> , 19 <u>86</u> , to <u>20 Jan</u> , 19 <u>86</u> , that (1) (we) lost <u>saw the deceased alive on</u> <u>19 Jan</u> , 19 <u>86</u> , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Anthony Bollino</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>20 Feb 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Bollino		22e. ADDRESS 955 Frederick St. Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB 24 1986		23c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL CEMT.		23d. LOCATION CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND		ADDRESS		25a. DATE REC'D. BY REGISTRAR EB 24 1986		25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>	

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Harry Barry McNeal

General Ward Hospital

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Dr. Jackson Collins

255 Frederick St., Cambridge, MD 21613

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 3 2

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA Mae METTS			2a. DATE OF DEATH MONTH 02 DAY 18 YEAR 86			2b. HOUR 10⁰⁵ AM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 06 DAY 15 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FROSTBURG VILLAGE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS / ZIP CODE Railroad St., Midland, Md. 21542		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE Railroad St., Midland, Md. 21542	
14. FATHER'S NAME John MIDDLE Poland		15. MOTHER'S MAIDEN NAME Harriet MIDDLE Dye		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATES) No		16b. SOCIAL SECURITY NO. 219-56-7557	
17. INFORMANT Marvin Metts, Railroad St, Midland, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarction CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 mo 4 mo		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 85 , to 1-30 , 19 86 , that (I) (we) last saw the deceased alive on 12-26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald E. Manger		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-18-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E. MANGER		22e. ADDRESS 55 JACKSON ST					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE OF BURIAL, CREMATION, REMOVAL 2-21-1986		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN Moscow Allegany Md.	

24. FUNERAL HOME NAME Lionhorn Funeral Home, Lonaconing, Md. ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 21 1986		25b. REGISTRAR'S SIGNATURE [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be kept by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified for post-mortem examination.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
1 DECEASED NAME (TYPE OR PRINT) Erma J. Miller					2a DATE OF DEATH MONTH DAY YEAR February 1, 1986		2b HOUR M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10 CITY OR TOWN OF DEATH Mt. Savage		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 Foundry Row				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b KIND OF BUSINESS OR INDUSTRY School		
13a STATE Maryland					13b COUNTY Allegany		13c CITY OR TOWN Mt. Savage		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John C. Blank					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Lewis					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 213-33-2211		17 INFORMANT ADDRESS Eugene R. Miller, Same as 13e					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure. DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent pneumonia and bronchiectasis DUE TO, OR AS A CONSEQUENCE OF (c) Tracheostomy & Retained Secretions. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic renal failure, depression										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE N.A. Ranjithan, M.D.					DEGREE		22c. DATE SIGNED 2/3/86		Md.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS Memorial Hosp. Med. Bldg., Cumberland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 4 '86		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Allegany, Md.			
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.					25. DATE RECEIVED BY REGISTRAR FEB 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

066161

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 3 4

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME FIRST MIDDLE LAST ADA E. MORRIS			2a DATE OF DEATH MONTH DAY YEAR February 22, 1986			2b HOUR 1428 M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		8b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp. & Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland			13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST James M. Clem			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine I. Wiles			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. 233-96-4273			17 INFORMANT Catherine Sherry			ADDRESS 11 Vermont Avenue Cumberland, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>The Syndrome Acute Left Ventricular Failure, Old age.</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Feb 22</u> , 19 <u>86</u> , to <u>Feb 22</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Feb 22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Dr. N. Ranjithan</u>			DEGREE			ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c DATE SIGNED 2/26/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ranjithan			22e ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 2-24-86		23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-MD.		
24 FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street=Cumberland, Md. 21502					25a DATE REC'D. BY REGISTRAR MAR 5 1986		25b REGISTRAR'S SIGNATURE <u>George Upchurch</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 3 5

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Premia M. Often			2a. DATE OF DEATH MONTH DAY YEAR 2 25 86			2b. HOUR 4:00pm			
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 8 92		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Allegany Co. Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Amcelle Celanese Corp.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Mechanic St., JFK Apts. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST John - Shertzter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine - Pryle			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			
16b. SOCIAL SECURITY NO. 214-07-2398			17. INFORMANT William Partlow			ADDRESS 25 Hawthorne Ave. Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Kidney Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Cirrhosis Heart Failure</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-25-86</u> to <u>2-25-86</u> , that (I) (we) last saw the deceased alive on <u>2-25-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Robustiano J. Barrera, Jr.</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-25-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robustiano J. Barrera, Jr.			22e. ADDRESS 17 Helman Drive, LaVale, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-28-86		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg-Allegany Co., MD.		
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502			25a. DATE REC'D. BY REGISTRAR MAR 5 1986			25b. REGISTRAR'S SIGNATURE <u>G. J. Anderson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 2 should be detached for use as the burial-transit permit). Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 3 6

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST ERCELL		MIDDLE LEONA		LAST PANNONE		2a. DATE OF DEATH MONTH FEB		DAY 19		YEAR 1986		2b. HOUR 1756		HRS M											
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH FEB		DAY 7		YEAR 1912		6 AGE (IN YEARS LAST BIRTHDAY) 74		YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 72 HRS DAYS		HOURS		MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD																							
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSP & MEDICAL CENTER																											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home																											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND																		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 106 E FIRST STREET/21502					
14. FATHER'S NAME FIRST Charles										MIDDLE A.		LAST Willingham		15. MOTHER'S MAIDEN NAME FIRST Eva										MIDDLE C.		LAST Trail			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217 10 4232		17 INFORMANT ADDRESS Mr. Armand M. Pannone, Cumberland, MD-husband																									
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>End stage CHF</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Restrictive pulm disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart CA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>																													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>H. Merrick</u>												DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. H. CURTIS MERRICK												22e. ADDRESS CUMBERLAND MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 02-22-1986				23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD																	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502												24b. DATE REC'D. BY REGISTRAR FEB 24 1986				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>													

MEDICAL CERTIFICATION

35

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29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

050164

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 3 7

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT ALLEN PRIDDY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1, 1986		2b. HOUR A M 0700				
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 03-15-1932		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 53		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanist		12b. KIND OF BUSINESS OR INDUSTRY railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 62 Boone Street/21502	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Priddy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Engle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 212-24-0025		17. INFORMANT ADDRESS Lenda Priddy, Cumberland, MD - wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Hodgkin's Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Qamar Zaman			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. QAMAR ZAMAN					22e. ADDRESS MEDICAL BUILDING MEMORIAL HOSPITAL, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 02-04-1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502					25a. DATE REC'D. BY REGISTRAR FEB 10 1986		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall		

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CHIEF OF POLICE

020101

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rehave with proper postage. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 6 0 3 3 3 8			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John R. Purdy, Sr.				Feb. 9, 1986			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1914		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH McCoole		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 221 Maryland Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Merchant Retail		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN McCoole		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John R. Purdy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna - Byrne		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232 10 5133	
17. INFORMANT ADDRESS Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Diabetes mellitus, Type II; Chronic renal failure; (R) cerebral hemisphere infarct 1981	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Phillip G. Staggers, M.D.	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip G. Staggers, M.D.		22d. ADDRESS 537 S. Mineral St., Keyser, W V 26726		22e. DATE SIGNED 2/10/86		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 Feb 1986		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.Va.	
24. FUNERAL DIRECTOR NAME Allen Rotruck		24b. DATE REC'D. BY REGISTRAR FEB 18 1986		24c. REGISTRAR'S SIGNATURE Julia Davidson-Randall		24d. REGISTRAR'S NAME Keyser, W.Va.	

DAVID WHITEHEAD

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 03339

1 DECEASED NAME (TYPE OR PRINT) RETA E Rafferty		2a DATE OF DEATH MONTH DAY YEAR 2 / 16 / 86		2b HOUR 9:40a M	
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 1 19 06		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY OWN HOME
13a STATE MARYLAND		13b COUNTY ALLEGANY	13c CITY OR TOWN BORDEN MINES	13d STREET ADDRESS / ZIP CODE RT. 2, FROSTBURG 21532	
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES BLANK		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ORT			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N.A. 214 07 1084		17 INFORMANT FOUNDRY ROW, MT. SAVAGE, MD MR. JOHN RAFFERTY, BOX 535,	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF fractured femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cond. Hypertension and Ketotic Diabetic DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 12 1986 to Feb 16 1986 , that (I) (we) last saw the deceased alive on Feb 16 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (we) did not view the body after death.					
22b. SIGNATURE Charles E. Oh		DEGREE MD		22c. DATE SIGNED 2/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Oh		22e. ADDRESS 4 STARN TERRACE, FROSTBURG, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/18/86	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD
24. FUNERAL DIRECTOR SOWERS FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR FEB 24 1986		25b. REGISTRAR'S SIGNATURE J. E. Miller	

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 4 0

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas R Rank			2a. DATE OF DEATH MONTH DAY YEAR 2/2/86			2b. HOUR 9:40p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1/28/05		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Alleg. MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL BOARD	
13a. STATE Maryland			13b. COUNTY Alleg		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST LEWIS RANK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH JENKINS			16. STREET ADDRESS / ZIP CODE 286 E Main ST, Frostburg, MD 21532			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.		17. INFORMANT ADDRESS FROSTBURG, MD 21532 MRS. THOMAS RANK, 286 E. MAIN ST.				
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MI & Arteriosclerotic heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD Emphysema Renal and hepatic failure.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-30</u> , 19 <u>78</u> , to <u>2/7</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>2/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S.L. Sandhir</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/6/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S.L. Sandhir			22e. ADDRESS 48 Tarn Terrace, X# Frostburg, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/5/86		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM PARK		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG ALLEGANY MD		
24. FUNERAL DIRECTOR <u>Sowers Funeral Home</u>			60 W. MAIN ST. Frostburg			25a. DATE REC'D. BY REGISTRAR FEB 11 1986			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please sign as co-registrars. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner(s) be notified at once.

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059024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

EICHORN FUNERAL HOME

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR 8 E. MAIN ST
LONA CONING, MD 21539

8 6 0 3 3 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE DORIS ELLEN		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1986		2b. HOUR 3:40 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1924	
6. AGE (IN YEARS LAST BIRTHDAY) 61		7. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing	
14. FATHER'S NAME Wilfrid Leonard Garlitz		15. MOTHER'S MAIDEN NAME Jeanette Stevenson Broadwater		16. SOCIAL SECURITY NO. 215 74 2832	
17. INFORMANT Miss Doris L. Ravenscroft		18. ADDRESS 21 Furnace St. Lonaconing, Md.		19. DATE OF OPERATION 2-26-86	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) non-traumatic pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF chronic kidney disease		21. APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH 2 hrs 6 yrs 10 yrs		22. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10	
23a. DATE OF OPERATION 2-26-86		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 24b. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		24c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 24d. LOCATION STREET CITY OR TOWN COUNTY STATE		24e. I certify that (I) (this hospital) attended the deceased from 1982 to 18 Feb 1986 , that (I) (we) last saw the deceased alive on 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
25a. SIGNATURE DR. DONALD MANGER		25b. DEGREE 25c. DATE SIGNED 2 23 86		25d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DONALD MANGER	
26a. ADDRESS LONA CONING, MD 21539		26b. BUREL, CREMATION, REMOVAL (SPECIFY) Burial		26c. DATE 2-26-86	
26d. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		26e. LOCATION Moscow Allegany Md		26f. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md.	
26g. DATE OF BURIAL FEB 26 1986		26h. REGISTRATION NO. 86		26i. SIGNATURE John E. Manger	

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1- FOR
STATE
REGISTRAR

SCARPELLI FUNERAL HOME

VIRGINIA AVE.,
CUMBERLAND, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 4 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MARGUERITE KATHERINE REED			2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1986			2b HOUR 6:50 AM				
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 02-28-1908		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7b UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY own home		
13a STATE MD			13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 312 Waverly Terrace/21502	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Hogan				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Gallagher						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-07-0311		17 INFORMANT ADDRESS Mr. Edward H. Reed, Cumberland, MD 21502						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Artery Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 11</u> 19 <u>86</u> to <u>Feb 13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>W. Hijab, MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/13/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALLY HIJAB, MD			22e. ADDRESS 909-A SETON DRIVE, CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-15-1986		23c. NAME OF CEMETERY OR CREMATORY St. Patricks Church			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502 ADDRESS										
25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 18 1986 <u>John Davidson-Randall</u>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial. Removal of this certificate from the State Dept. of Health and Mental Hygiene is prohibited. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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RECEIVED
FEBRUARY 1950

MR. HENRY J. LEE

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ALLEGANY COUNTY

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 4 3

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (1 TYPE OR PRINT) Blanche Leota Rephann		2a. DATE OF DEATH MONTH DAY YEAR 2-17-86		2b. HOUR 6 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1906	
7a. BIRTHPLACE (STATE OR FOREIGN) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing Home Center	
12a. USUAL OCCUPATION (IF DECEASED WAS NOT AT WORK, GIVE INDUSTRY) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS Rt. 2, Box 171, Cumberland Md.	
13b. CITY OR TOWN OF DEATH Allegany		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME Elijah S. Winter	
15. MOTHER'S MAIDEN NAME Eleanor Coons		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATES) No		16b. SOCIAL SECURITY NO. 214-48-3149	
17. INFORMANT Eleanor Muir		18. ADDRESS Rt 8, Box 311, Cumberland, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/15/84 to 2/17/86 , that (I) (we) last saw the deceased alive on 2/17/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE P. HAZMOS		22c. ADDRESS 302 Schley St Cumberland Md		22d. DATE SIGNED			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		22g. DATE SIGNED			

23a. BURIAL, CREMATION, REMOVAL (SP) Burial		23b. DATE Feb. 20, 1986		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION Allegany Md	
24. FUNERAL HOME NAME Edithorn Funeral Home ADDRESS Lonaconing, Md.		25a. DATE REC'D. BY REGISTRAR FEB 24 1986		25b. REGISTRAR'S SIGNATURE John D. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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Mr. J. H. Jones, Jr., Secretary, U.S. Department of the Interior, Washington, D.C.

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050043

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARNOLD A. ROBERTSON			2a. DATE OF DEATH MONTH DAY YEAR February 11, 1986		2b. HOUR 8:45 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1924		
6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Mgr. & Treas.		
12b. KIND OF BUSINESS OR INDUSTRY Liberty Milk Co.		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Allegany		
13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1311 E. Oldtown Rd. / 21502		
14. FATHER'S NAME FIRST MIDDLE LAST Raymond D. Robertson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice - Messick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII & Korea 218-16-4476		17. INFORMANT ADDRESS Anna M. Robertson-Address same as #13 above.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Respiratory failure 2° to COPD</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>2-11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Dr. Judy Stone</u>		DEGREE		22c. DATE SIGNED 2-11-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Judy Stone		22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-14-86		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-MD.		24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502				
25a. DATE REC'D. BY REGISTRAR FEB 14 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rondelet</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/funeral permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OVERVIEW

10/10/2000

2000

050160

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03345	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JASON CLINTON SCHAEFFER							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-3-86 19		7b. HOUR 4:06P		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 04-20-1972		6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.		7c. DATE PRONOUNCED DEAD 2-3-86 19		7d. HOUR 4:06P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD		
11. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Railroad Bridge				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student			12b. KIND OF BUSINESS OR INDUSTRY middle school	
13a. STATE WV						13b. CITY Mineral		13c. CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert C. Schaeffer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elma J. Buser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elma J. Schaeffer, Ridgeley, WV			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last 9108										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 2:30M. 2-3-86 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in water					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Western Maryland Cumberland, Maryland Railroad Bridge					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 2-4-86			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 02-07-1986		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gard.			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

DPH-17
(VR A15 ME (5))

PUSH MOTION

CANDIDATE



055058

LEASURE-STEIN FUNERAL HOME

STATE OF MARYLAND

FOR STATE REGISTRAR
230 BALTIMORE AVENUE
CUMBERLAND, MD. 21502DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALEXANDER JAMES SCHUTE		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11, 1986		2b. HOUR 11:40AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofer		12b. KIND OF BUSINESS OR INDUSTRY Roofing		13. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
14. FATHER'S NAME FIRST MIDDLE LAST William L. Schute		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara M. Martz		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---	
17. INFORMANT ADDRESS 788 Fayette Street Cumberland, MD		18. SOCIAL SECURITY NO. 214-05-8536		19. STREET ADDRESS / ZIP CODE 10 N. Liberty St. 21502	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart attack, subdural (R)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma prostate w/ metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Agustino</u>				DEGREE MD		22c. DATE SIGNED 2/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AUGUSTO FIGUEROA, M.D.				22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/86		23c. NAME OF CEMETERY OR CREMATORY SS Peter And Pauls		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home				25a. DATE REG'D. BY REGISTRAR FEB 20 1986			
230 Baltimore Ave. Cumberland, MD 21502				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

BP

LEASER-STEIN FEDERAL HOME
220 BALTIMORE AVENUE
CLIFTON, N.J. 07011

ALLEGANY DISTRICT
FEBRUARY 10, 1986
11:00A

ALLEGANY COUNTY

THE DISTRICT ATTORNEY



ALLEGANY COUNTY DISTRICT ATTORNEY
CLIFTON, N.J. 07011

055057

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 4 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
BEATRICE NAOMI SHEALLY		February 13, 1986	
3. SEX		4. RACE	
Female		White	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Dec. 19, 1907		78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
West Virginia		U.S.A.	
8. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cumberland		Allegany MD.	
10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Memorial Hospital		Dorm Supervisor	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
State		Paca Street 21502	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Arvey L. Durrett		Lettie Brant	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		213-40-3909	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
Ronald L. Sheally 710 Gephart Dr. Cumberland, MD		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain negative sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		<u>immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>possible acute leukemia & system, multiple myeloma, chronic renal failure, respiratory system, & thrombocytopenia</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Dr. Anthony Bollino</u>		17 Feb 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Dr. Anthony Bollino		955 Frederick Street Cumberland, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		2/17/86	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Rose Hill Cemetery		Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Leasure-Stein Funeral Home		Feb 20 1986	
230 Baltimore Ave. Cumberland, MD 21502			

MEDICAL CERTIFICATION

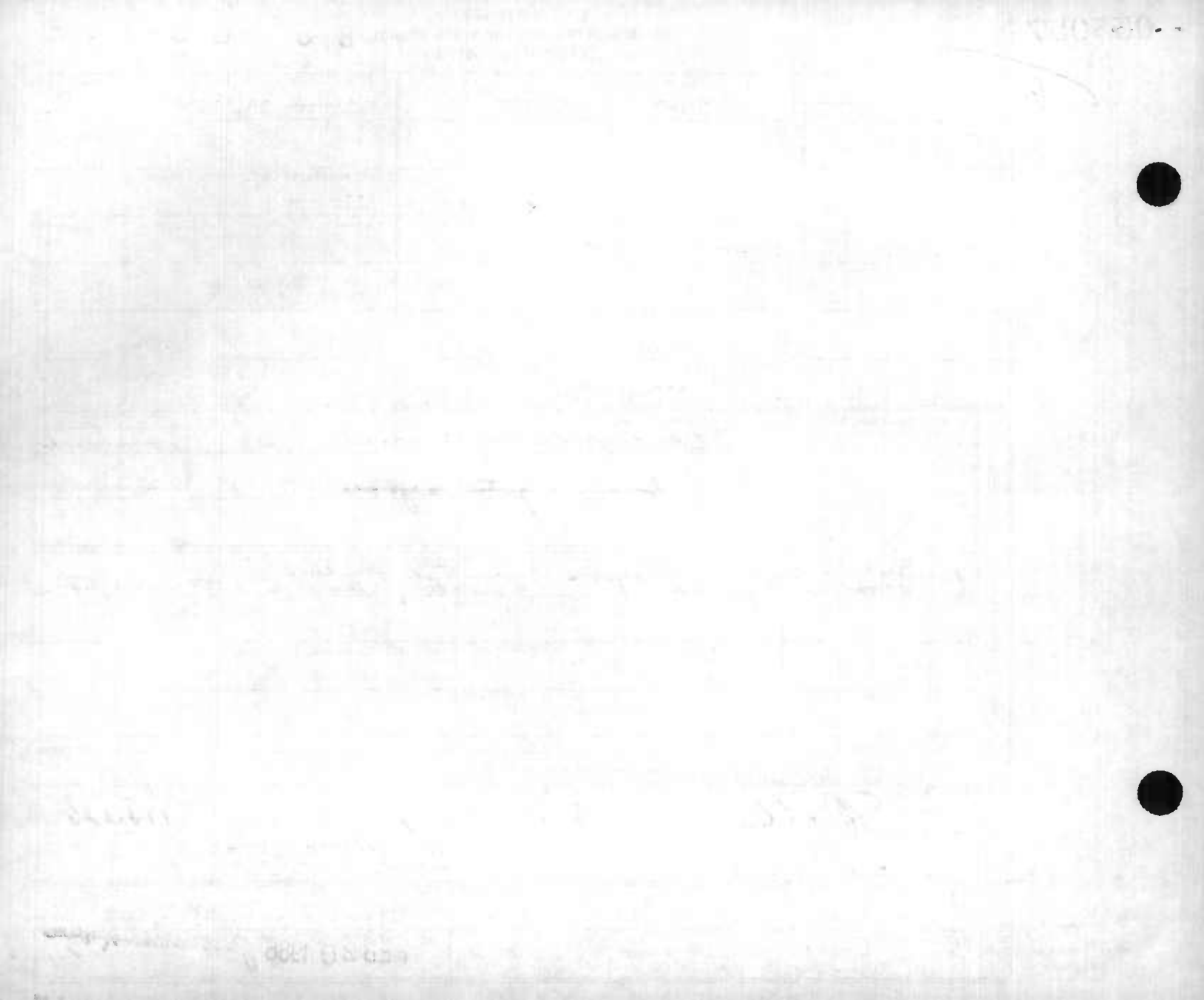
9 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



045173/

FOR
1- STATE
REGISTRAR

LEASURE STEIN F.H.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONA ROSALIE SHERMAN			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 5, 1986		2b. HOUR 2:40 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 26, 1924	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE West Virginia		13b. COUNTY Mineral	13c. CITY OR TOWN Ridgeley	13d. STREET ADDRESS / ZIP CODE Rt. 2 Box 446 26753	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis A. Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose D. Bradford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---	17. INFORMANT ADDRESS Carl W. Sherman same as 13a-e.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Cancer bladder metastasize to spine</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Pneumonia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/1985</u> to <u>2/4/1986</u> , that (I) (we) lost saw the deceased alive on <u>2/4/1986</u> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN			22c. DATE SIGNED <u>2/6/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RIAZ JANJUA, MD		22e. ADDRESS MEMORIAL MEDICAL BLDG, CUMBERLAND, MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/7/86	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial park	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Alleg. MD
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR FEB 13 1986	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
230 Baltimore Ave. Cumberland, MD 21502			

2024 COTTON FIBER

LEAFLET STEP F.R.

042173

FEBRUARY 2, 1985

SEATTLE

WALLIE

LENA

ALLEGANY COUNTY



SACRED HEART HOSPITAL



RECEIVED MEDICAL BLDG. CUMULATIVE NO. 2340

DATE: 1/18/85

050161

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03349	
1. DECEASED NAME (TYPE OR PRINT) MICHAEL TODD SHIPLEY			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2-3-86 19			2b. HOUR M 4:06P					
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12-31-1971	6. AGE (IN YEARS) LAST BIRTHDAY 14 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-3-86 19		7d. HOUR 4:06P			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Railroad Bridge			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student		12b. KIND OF BUSINESS OR INDUSTRY middle school				
13a. STATE WV			13b. COUNTY Mineral	13c. CITY OR TOWN Ridgeley	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 42 Carpenter Avenue/26753					
14. FATHER'S NAME FIRST MIDDLE LAST Robert Joseph Shipley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JoAnn Stotts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Robert J. & JoAnn Shipley, Ridgeley, WV						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in water								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Western Maryland Railroad Bridge Cumberland, Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 2-4-86					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street								
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 02-06-1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md 21502			ADDRESS FEB 10 1986			25a. DATE REC'D. BY REGISTRAR John H. ...					
25b. REGISTRAR'S SIGNATURE <i>John H. ...</i>											

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(VR A15 ME (5))

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MINTEP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MABEL SUSAN SIEBERT			2a. DATE OF DEATH MONTH DAY YEAR 02 18 86			2b. HOUR 2120H M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 15 08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CUMBERLAND ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aid		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Monroe Phillips			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Cassell			13e. STREET ADDRESS 102 Virginia Avenue/21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-52-1573		17. INFORMANT ADDRESS Mr. Charles Kinsman, Keyser, WV - son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Stenocardiac Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Generalized atherosclerosis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10 April 1985 , to 2-18 1986 , that (I) (we) last saw the deceased alive on 2-18 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Ranjithan			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-19-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RANJITHAN			22e. ADDRESS Memorial Hospital, Cumberland, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-21-1986		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME SCARPELLI, JAMES F.			ADDRESS CUMBERLAND MD 21502			25a. DATE REC'D. BY REGISTRAR FEB 24 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

068103

NAME: FEVLE
RACE: WHITE
DOB: 08 12 08
AGE: 38
SEX: M
COUNTRY: USA
CITY: CAMBERLAND ALABAMA COUNTY
US 18 06 2120

814-22-1272
Camberland, Alabama
Address: 1000 1st Street

Consolidated

2-18 82 11-1 82 5-18 82

2-11-82 X

11/1/82

DR. RALPH DAVIS

CAMBERLAND MD

100% COTTON FIBER
MADE IN ALABAMA

066107

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be called and a report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR 404 DECATUR ST. CUMB.MD. CERTIFICATE OF DEATH									
REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL MAY SIMMONS						2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 18, 1986		2b HOUR 10:25AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR SEPT. 24 1903		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY ----	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN CUMBERLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 603 PINE AVENUE 21502	
14 FATHER'S NAME FIRST MIDDLE LAST DANIEL T. O'BRIEN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIZZIE -----					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215205435		17 INFORMANT ADDRESS TERRY MACKERT RFD 1 BOX 408 RIDGELEY W.VA.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF & pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Severe CHD DUE TO, OR AS A CONSEQUENCE OF (c) High probability of recurrent Pulm. Embolism APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Deep Vein Thrombosis - Dissects II - Hypertension									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 2/10/86 to 2/18/86, that (I) (we) last saw the deceased alive on 2/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE V. RAUL FELIPA, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 2/18/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. RAUL FELIPA, M.D.				22e ADDRESS 925 BISHOP WALSH RD. CUMBERLAND, MD. 21502					
23a BURIAL, CREMATION, REMOVAL (SPEC) BURIAL		23b DATE FEB 20 1986		23c NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND			
24 FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND				25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE FEB 21 1986					

BP

066107

- ELIXIR-WHITE-THERMAL-ROSE
804 DECATUR ST. CIND. MD.

EDER MAY SIMONE

FEBRUARY 18, 1986

10:12

ALLEGANY COUNTY

SACRED HEART HOSPITAL

21520472

202 RIVINGTON RD. CUMBERLAND, MD. 21502

W. PAUL KELLEY, D.D.

070176

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. HAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03352	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST BROWN			MIDDLE			LAST SINES		
2a. DATE KNOWN OF DEATH		<input type="checkbox"/> ESTI- <input checked="" type="checkbox"/> MATED		MONTH DAY YEAR		2b. HOUR					
2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
male Male		white		July 17, 1917		68 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.			U.S.A.						Allegany MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			315 Frederick St.			Const.			Laborer		
13a. STATE			13b. CITY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Richard			Minnie			Yes			213-18-2765		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Kathryn Sines			Myocardial Infarction			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
4830 Wright Ave.			Chronic Alcoholism			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Baltimore, Md.			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		
						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED		
									21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		
									21f. LOCATION		
									21g. CITY OR TOWN		
									21h. COUNTY		
									21i. STATE		
									21j. DATE REC'D. BY REGISTRAR		
									21k. REGISTRAR'S SIGNATURE		
									21l. DATE REC'D. BY REGISTRAR		
									21m. REGISTRAR'S SIGNATURE		
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WINTER

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03353

1. DECEASED NAME (TYPE OR PRINT) Henry E. Smiley		2a. DATE OF DEATH MONTH DAY YEAR February 19 1986		2b. HOUR M 11	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 22 1893	
6. AGE (IN YEARS LAST BIRTHDAY) 92		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		8. CITIZEN OF WHAT COUNTRY? usa	
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County		10. CITY OR TOWN OF DEATH Westernport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 442 Spruce St	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Paper		13a. STREET ADDRESS 442 Spruce St.	
13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Smiley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Myers		16. SOCIAL SECURITY NO. 216-05-9715	
17. INFORMANT Mr. Paul Smiley		18. ADDRESS Westernport, Md. 21562		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days 15 yrs		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	
21a. DATE OF OPERATION 2/22/86		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emphysema		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) aspiration pneumonia	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) at home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 442 Spruce St. Westernport Allegany Md.	
22a. I certify that (I) (this hospital) attended the deceased from 2/14/86 to 2/19/86 , that (I) (we) lost saw the deceased alive on 2/14/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Donald F. Mangia		22c. DATE SIGNED 2/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD F. MANGIA		22e. ADDRESS 55 Jackson St. Inverness 21539		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/22/86		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.		24. FUNERAL DIRECTOR NAME ADDRESS Boals Funeral Service Westernport, Md. 21562		25a. DATE REC'D. BY REGISTRAR MAR 3 1986	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR
STATE
REGISTRARROTRUCK FUNERAL HOME
KEYSER, WVA 26726STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 3 3 5 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Angus Smith			2a. DATE OF DEATH MONTH DAY YEAR February 9, 1986		2b. HOUR 02:40a m				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec 1, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drag Line Oper.		12b. KIND OF BUSINESS OR INDUSTRY Coal Co.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va.			13b. COUNTY Mineral		13c. CITY OR TOWN Burlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE Rt 1 Box 146A 26710			14. FATHER'S NAME FIRST MIDDLE LAST Mercer - Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie - Bruce		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 234483021/1		17. INFORMANT ADDRESS V. Jean Smith Rt 1 Burlington. W.Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of rectum and colon DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2-9-86 to 2-9-86 , that (I) (we) last saw the deceased alive on 2-9-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. John Mehanna					DEGREE M.D.		22c. DATE SIGNED 2-10-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Mehanna, MD					22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12 Feb 86		23c. NAME OF CEMETERY OR CREMATORY Dolly Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burlington Mineral W.Va.		
24. FUNERAL DIRECTOR NAME Allen Rotruck Keyser, W.Va.					25a. DATE REC'D. BY REGISTRAR FEB 18 1986				
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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ROTUNDA FUNERAL HOME
KEYSER, WVA 25726

Black
Dec 1, 1958

W. Va.
U.S.A.
Cumberland
SACRED HEART HOSPITAL
W. Va. Mineral Burlington
at 1 - 02 1100 25710
Long Line Oper. Coal Co.

Robert - Smith
-
V. Jean Smith at 1 Burlington, W. Va.

W. Va. 25726
Burlington Cemetery
Burlington Mineral W. Va.
000-8 FETTER DRIVE, CUMBERLAND MO 64703

STUART FUNERAL HOME OAKLAND, MD. 21550

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8 0 0 3 3 5 5

REGISTRAR			REG. NO.		
DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR		
RICHARD ALLEN TERRANT			JANUARY 28, 1986		
3 SEX			4 RACE		
Male			White		
5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		
March 29, 1963			22 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		
Maryland			USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Cumberland			ALLEGANY COUNTY MD.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
Cumberland			SACRED HEART HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Disabled			-----		
13a. STATE			13b. COUNTY		
Maryland			Garrett		
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Oakland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE			13f. STREET ADDRESS / ZIP CODE		
Rt. 3 Box 141			21550		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Tony ----- Terrant			Isabelle Florence Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
no			218885570		
17 INFORMANT			17 ADDRESS		
Tony Terrant			See #13 above		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>					Minutes
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>					Days
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dysentery Nausea Vomiting Deformations</u>					Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
Jan. 20, 1986		Correct Foot & Ankle Deform.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>XXXXX</u> attended the deceased from <u>Jan. 28, 19 86</u> to <u>Jan. 28, 19 86</u> , that (I) <u>XX</u> saw the deceased alive on <u>Jan. 28, 19 86</u> , and that in (my) <u>XX</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>XX</u> did not see the body after death.)					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Signature</u>				1/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JACK W. HARVEY, M.D.		925 SETON DRIVE CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/31/86		Garrett Co. Mem. Gdns.	
24 FUNERAL DIRECTOR NAME		24 ADDRESS		24 CITY OR TOWN COUNTY STATE	
Bradley A. Stewart		32 S. 2nd St. Oakland Md.		Oakland, Garrett Maryland	

0-1529

JANUARY 28, 1968

ALLEGANY COUNTY

100000000

100000000

SEE RETURN IN THE CUPBOARD, NO. 100000000

100000000

065079

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 5 0
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
MABEL		IDELLA		THOMAS		February 16, 1986	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
female		white		02-10-1908		78 YRS	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
PA		USA				Allegany MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		Memorial		Housewife		own home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE	
MD		Allegany		Cumberland		918 Maryland Avenue/21502	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
George Ernst		Lydia Mazer		no		214-05-8434	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Vallie Schmidt - Cumberland, MD - niece				PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>End Stage CHF</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Dr. Fiscus		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		500 Memorial Ave., Memorial Med. Bldg Cumberland, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		02-20-1986		Greenmount Cemetery		Cumberland Allegany MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, MD 21502		FEB 20 1986					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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070154

Items 5+6 per phone

FOR
STATE
REGISTRAR
3/11/86 DRDSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 03357

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILFRED Sabestine TULLEY						2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/20/86			2b. HOUR 4:00 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07/02/04		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 81		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY				10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12707 N. CRESAP ST. BOWLING GREEN RETIRED B&O RAILROAD			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOWLING GREEN				12b. KIND OF BUSINESS OR INDUSTRY 21502				13a. STATE MARYLAND			
13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 12707 N. CRESAP STREET				14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM TULLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA JANE DONNELLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 705-12-6953				17. INFORMANT ADDRESS TEMPLE CITY CALIF. 91780			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF HEAD AND NECK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE NO			
22. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>				TITLE (SPECIFY) ASST				DATE SIGNED 2/22/86			
EXAMINER'S NAME (TYPE OR PRINT) GIOVANNI MASTRANGELO				ADDRESS 772 BISHOP WALSH DRIVE CUMBERLAND MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE FEB 27 1986				23c. NAME OF CEMETERY OR CREMATORY GREEN RIDGE MEMORIAL PARK			
23d. LOCATION CITY OR TOWN COUNTY STATE CONNELLSVILLE FAYETTE PENNA.				23e. DATE RECD. BY REGISTRAR FEB 28 1986				23f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			
24. FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND											

DIVISION OF VITAL RECORDS, 300 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 300 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH-17
(VR A15 ME (1))
15M 2/80

063012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 3 3 5 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THERESA JEAN VANORMER			2a. DATE OF DEATH MONTH DAY YEAR February 27, 1986		2b. HOUR MIN. 10:00 pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1912		
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office-Kelly Springfield		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STREET ADDRESS / ZIP CODE 319 Sunset Drive / 21502		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. COUNTY Allegany		
14. FATHER'S NAME FIRST MIDDLE LAST Irving Thomas Holland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Mae Tatroe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-07-0748		17. INFORMANT ADDRESS W. Alfred Van Ormer - Address same as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF pneumonia ? Viral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 2/13/86 to 2/27/86 that (we) last saw the deceased alive on 2/27/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Shawn A. Miller DEGREE		
22c. DATE SIGNED 3/5/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Raver		22e. ADDRESS Memorial Hospital Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-2-86		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland-Allegany Co.-Md.		24. FUNERAL DIRECTOR NAME ADDRESS George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR MAR 6 1986		
25b. REGISTRAR'S SIGNATURE W. Alfred Van Ormer						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (Important: If item 21 is marked as item 1, show any injury, or other traumatic event, the medical examiner will be notified at once.)

052132

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 5 9

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA IVA VARNER			2a DATE OF DEATH MONTH DAY YEAR February 6, 1986		2b HOUR 9:05 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 27, 1917		
6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS MONTHS DAYS HOURS MIN.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegheny County MD.				
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		
12b KIND OF BUSINESS OR INDUSTRY Domestic		13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN W. Va. Hampshire Shanks				
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Route 50 26761				
14 FATHER'S NAME FIRST MIDDLE LAST Charles Taylor McBride			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lille Bowen			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 234-64-3760		17 INFORMANT ADDRESS Virgil B. Lambert Franklin, W. Va 26807		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myeloid leukemia. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Dr. Zaman		22c DEGREE MD		22d ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Zaman		22f ADDRESS 500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2/9/86		23c NAME OF CEMETERY OR CREMATORY Davis Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Davis Tucker W. Va.		23e DATE REC'D. BY REGISTRAR FEB 14 1986				
24 FUNERAL DIRECTOR NAME James R. Lyles		24b ADDRESS Box 124 Augusta, W. Va.		24c REGISTRAR'S SIGNATURE Julie Davidson-Randall		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 would be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Jan 27, 1917

Albany County

Albany County

Albany County

1917

Jan 27

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Albany County

052180

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove and complete pages 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic evidence, a medical examiner must be notified in writing.

BP. _____

DHMM - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
60 WEST MAIN STREET
FROSTBURG, MD 21532

8 6 0 3 3 6 0

1- FOR
STATE
REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA NMI VOGTMAN			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 9, 1986		2b. HOUR 10:30AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4/28/ 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY LAEMMERT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE BRODE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N.A. 220-28-9900	
17. INFORMANT FROSTBURG, MD 21532		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia</u> (b) <u>Severe Pneumonia with</u> DUE TO, OR AS A CONSEQUENCE OF <u>Recurrent atelectasis of left lower lobe</u> (c) <u>Arterio sclerosis, CHF. Cardiac arrhythmia - old age failure of heart</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>86</u> , to <u>2/9</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/8/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>SIKANDER SANDHIR</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <u>2/9/86</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIKANDER SANDHIR, MD		22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE 2/11/86		23c. NAME OF CEMETERY OR CREMATORY GERMAN LUTHERAN CEM FROSTBURG ALLEGANY MD		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR <u>60 W. MAIN ST.</u> BOWEN'S FUNERAL HOME FROSTBURG	
25a. DATE REC'D. BY REGISTRAR FEB 13 1986		25b. REGISTRAR'S SIGNATURE <u>John T. ...</u>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

013100

55 WEST MAIN STREET
FROSTBURG, MD 21532

CLARK MARI WESTMAN FEBRUARY 2, 1982 10:30A

ALLEANY COUNTY

SACRED HEART HOSPITAL

ALL COUNTY FROSTBURG MD

ALBANY

ALBANY

220-22-0000 W. WILLIAM WESTMAN FROSTBURG MD

SIMPLES EPOCHIR, MD

NO TARI TRAPAC, FROSTBURG, MD 21532

21532 FROSTBURG MD 21532

062093

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Herman G. Washington			2a. DATE KNOWN OF DEATH 2 24 86			2b. HOUR 1635		
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 1 26 01	6. AGE (IN YEARS) 85 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 2 24 86	7d. HOUR 1635	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman/Oiler		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Hite			15. MOTHER'S MAIDEN NAME Martha		16. STREET ADDRESS 225 Wallace Street			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 232-10-5565A		17. INFORMANT Kathleen Washington			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest Acute congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of the prostate								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE [Signature]			TITLE (SPECIFY) M.D. Dpty			DATE SIGNED 2-24-86		
EXAMINER'S NAME (TYPE OR PRINT) PAUL SNOW, M.D.			ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/86		23c. NAME OF CEMETERY OR CREMATORY SS Peter & Pauls		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD		
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR FEB 27 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

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(VR A15 ME (5))

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SAN FRANCISCO, CALIF 94304

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U.S. AIR FORCE
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SAN FRANCISCO, CALIF 94304

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FOR
STATE
REGISTRATION
1- STATE 359-3820

EICHORN FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 3 3 6 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID WALTER WEIR			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1986			2b. HOUR 8:50P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (LAST WORK OR TRAVEL OF WORKING INDUSTRY) Ret. Coal Miner			12b. KIND OF BUSINESS OR INDUSTRY and Farmer Md.		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY OR TOWN Garrett Lonaconing			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13. STREET ADDRESS / ZIP CODE Rt 1, Box 50, Lonaconing, 21539 Md.		
14. FATHER'S NAME James			MIDDLE Weir LAST			15. MOTHER'S MAIDEN NAME Olive			MIDDLE Hansel LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO None (WAR OR DATES)			17. INFORMANT Lillie F. Weir, Rt 1, Box 50, Lonaconing, Md.			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recent Staphylococcal pneumonia; Dementia of Alzheimer type; prostatic cancer</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11</u> 19 <u>86</u> , to <u>Feb 15</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Feb 15</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas Devlin</u> MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-16-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS DEVLIN, M.D.			22e. ADDRESS 55 JACKSON STREET LONACONING, MD. 21539								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-19-1986			23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			23d. LOCATION Moscow Allegany Md. STATE		
24. EICHORN Funeral Home, Lonaconing, Md. EICHORN Funeral Home, Lonaconing, Md.						25a. DATE REC'D. BY REGISTRAR FEB 20 1986			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

02113

ELIOT RUMBLE LINE
750-7270

FEBRUARY 12, 1988

DAVID WALTER

88

Feb. 22 1987

ALLICAN COUNTY

SACRED HEART HOSPITAL

James

James

Five

Five

James

to, box 50, London, Md.

James

James

to

10000 STREET LONDON, MD 21110

TRANS CREDIT

Part 1 - 2-12-1988 - View Cemetery - in view of James M.

Elizbeth, General Home, London, Md.

Stewart's
051213STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 6 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROXADELLA B WHITEHEAD			2a. DATE OF DEATH MONTH DAY YEAR February 2, 1986		2b. HOUR: 7:35 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2/1/1918		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS / ZIP CODE P.O. Box 13 26739		13b. COUNTY Grant		
13c. CITY OR TOWN Mt. Storm		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STATE WVa.		
14. FATHER'S NAME FIRST MIDDLE LAST Robert ----- Clem		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl ----- Clem				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 234-44-6750		17. INFORMANT ADDRESS Allen S. Whitehead see #13 above		
18. CAUSE OF DEATH (Enter only one cause per line form (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF, (b) PNEUMONIA - NON RESOLVING DUE TO, OR AS A CONSEQUENCE OF, (c) CA-LUNG-ADENOCARCINOMA-METASTATIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: SEPSIS - SOURCE ? TO MYCOP						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY LAT HOME, STREET, FACTORY, OFFICE, FARM, ETC.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/22 19 86 , to 2/2 19 86 , that I saw the deceased alive on 2/2 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (or did not view the body after death).						
22b. SIGNATURE James M. Raver MD				22c. DATE SIGNED 2/3/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Raver		22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/5/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Storm Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Storm Grant West Virginia		24. FUNERAL DIRECTOR NAME ADDRESS Bradley A. Stewart Oakland, Maryland 21550				
25a. DATE REC'D. BY REGISTRAR FEB 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

02133

20% COTTON RIBBED

DAVID WHITEH

[Faint, illegible handwritten text, possibly a signature or address]

FEB 1 1937

052140

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 6 4

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HAZEL MAE WIEBEL			2a. DATE OF DEATH MONTH DAY YEAR February 10, 1986			2b. HOUR P M 2:25 P			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 04-12-1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 72 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 718 Oldtown Road/21502									
14. FATHER'S NAME FIRST MIDDLE LAST M.P. Perry					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Wilson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-05-6221			17. INFORMANT ADDRESS Mr. Thomas B. Cumiskey, Cumberland, MD-friend			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

Congestive Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

Ischemic Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF

Coronary artery Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/8/86, to 2/10/86, that (I) (we) last saw the deceased alive on 2/10/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Halmos				22e. ADDRESS Memorial Hospital Cumberland, Md. 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-12-1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25. BAL RECORD BY REGISTRAR FEB 14 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the body from the hospital. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

100% COTTON FIBER

WILFANN DEND



100% COTTON FIBER

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 6 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary M Williams			2a DATE OF DEATH MONTH DAY YEAR 2/14/86			2b HOUR 5:00a M								
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2/26/11		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Alleg. MD.								
10 CITY OR TOWN OF DEATH Frostburg		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b KIND OF BUSINESS OR INDUSTRY CHURCH						
13a STATE Maryland			13b COUNTY Alleg		13c CITY OR TOWN Frostburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 21532 1 Kaylor Circle, Frostburg					
14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL E. FLANIGAN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE BRADY											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 220 10 7376		17 INFORMANT ADDRESS FROSTBURG, MD 21532 MRS. MARCELLA DICKERHOOF, 208 W. MECHANIC									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cognitive Heart Failure & Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a pneumonia														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (ENT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (i) this hospital attended the deceased from Jan 20, 1986 to Feb 14, 1986 , that (ii) (we) last saw the deceased alive on Feb 14, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did (did not) view the body after death.														
22b SIGNATURE Charles E. Oh M.D.						DEGREE M.D.		22c DATE SIGNED Feb 14, 86						
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Oh						22e ADDRESS Frostburg, MD 21532								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 2/17/86		23c NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEM.			23d LOCATION CITY OR TOWN COUNTY STATE MT. SAVAGE, ALLEGANY MD						
24 FUNERAL DIRECTOR M. Sowers Sowers FUNERAL HOME ADDRESS 60 W. MAIN ST. FROSTBURG											25a DATE REC'D. BY REGISTRAR FEB 19 1986		25b REGISTRAR'S SIGNATURE John Kaylor-Rendell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a post-mortem examination should be performed.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

STATE OF

NEW YORK

IN RESPONSE TO A

RESOLUTION OF THE

SENATE PASSED

APRIL 10, 1890

AND A RESOLUTION OF THE

ASSEMBLY PASSED

MARCH 10, 1890

RELATIVE TO THE

LANDS BELONGING TO

THE STATE OF NEW YORK

AND THE LANDS BELONGING TO

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ALBANY: J. B. LIPPINCOTT & CO. 1890

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 3 3 6 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLYDE ROYCE WILLISON			2a. DATE OF DEATH MONTH DAY YEAR February 27, 1986		2b. HOUR 8:12 P.M.		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR NOV 4 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED SERVICE		12b. KIND OF BUSINESS OR INDUSTRY STATION ATT.	
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST LEMUEL WILLISON		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELLEN BRANT		13e. STREET ADDRESS / ZIP CODE 40 MARION STREET 21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-1503		17 INFORMANT ADDRESS THOMAS WILLISON 29 MORAN AVE CUMBERLAND MD.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Brainstem CVA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Chronic Obstruction Lung Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE		22c. DATE SIGNED 3-1-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Fiscus				22e. ADDRESS 500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 1 1986		23c. NAME OF CEMETERY OR CREMATORY ST LUKES CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.				25a. DATE REC'D. BY REGISTRAR MAR 04 1986			

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NOTED & OK

CHETWIN